# Bromhexine for COVID-19: real-time meta analysis of 7 studies

@CovidAnalysis, July 2025, Version 22
https://c19early.org/bmeta.html

## Abstract

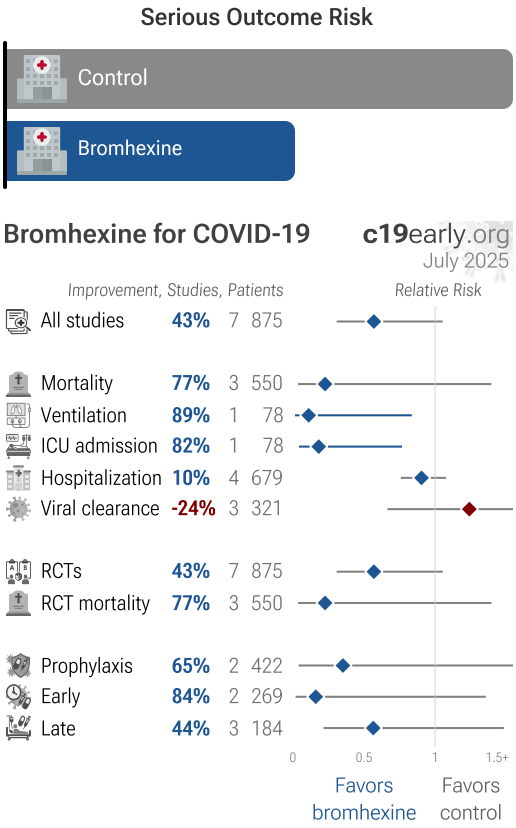
Significantly lower risk is seen for ventilation and ICU admission. 3 studies from 3 independent teams in 2 countries show significant benefit.

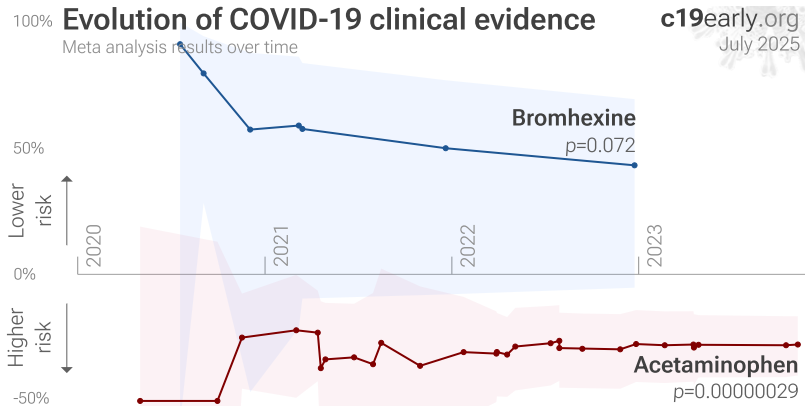
Meta analysis using the most serious outcome reported shows 43% [-5-69%] lower risk, without reaching statistical significance. Results are similar for peer-reviewed studies. Early treatment is more effective than late treatment. Currently all studies are RCTs.

2 RCTs with 304 patients have not reported results (up to 4 years late) [1,2].

Bromhexine efficacy may vary depending on the degree of TMPRSS-dependent fusion for different variants [3,4].

No treatment is 100% effective. Protocols combine safe and effective options with individual risk/benefit analysis and monitoring. All data and sources to reproduce this analysis are in the appendix.



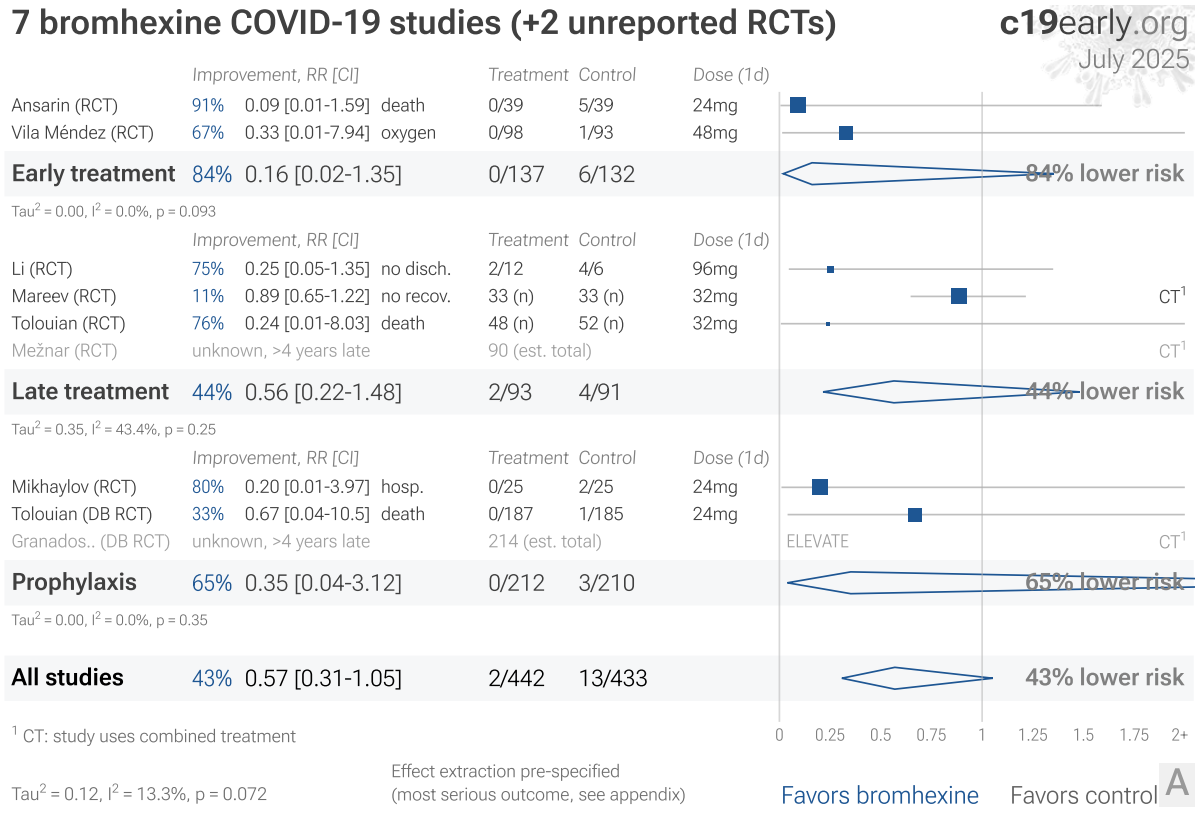

### BROMHEXINE FOR COVID-19 — HIGHLIGHTS

Bromhexine reduces risk with low confidence for mortality, ventilation, ICU admission, cases, and in pooled analysis, and very low confidence for recovery, however increased risk is seen with very low confidence for viral clearance.

Efficacy may vary depending on the degree of TMPRSS-dependent fusion across variants.

Early treatment is more effective than late treatment.

Real-time updates and corrections with a consistent protocol for 172 treatments. Outcome specific analysis and combined evidence from all studies including treatment delay, a primary confounding factor.



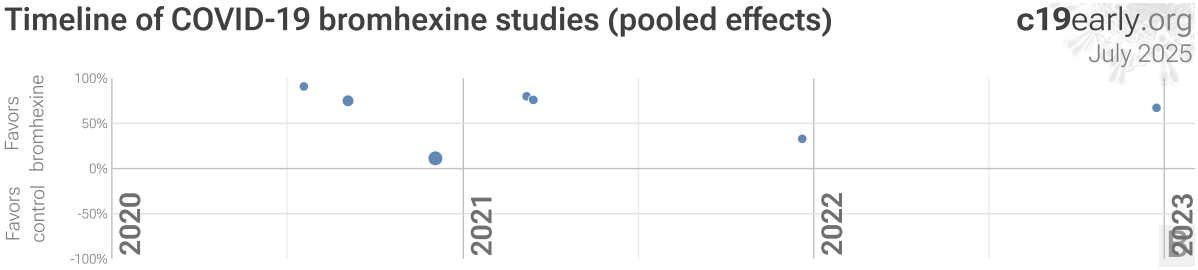




***Figure 1.* A. Random effects meta-analysis.** This plot shows pooled effects, see the specific outcome analyses for individual outcomes. Analysis validating pooled outcomes for COVID-19 can be found below. Effect extraction is pre-specified, using the most serious outcome reported. For details see the appendix. **B. Timeline of results in bromhexine studies.**

# Introduction

## Immediate treatment recommended

SARS-CoV-2 infection primarily begins in the upper respiratory tract and may progress to the lower respiratory tract, other tissues, and the nervous and cardiovascular systems, which may lead to cytokine storm, pneumonia, ARDS, neurological injury[6-18] and cognitive deficits[9,14], cardiovascular complications[19-23], organ failure, and death. Even mild untreated infections may result in persistent cognitive deficits[24]—the spike protein binds to fibrin leading to fibrinolysis-resistant blood clots, thromboinflammation, and neuropathology. Minimizing replication as early as possible is recommended.

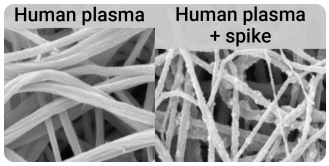



***Figure 2.* SARS-CoV-2 spike protein fibrin binding leads to thromboinflammation and neuropathology, from[5].**

## Many treatments are expected to modulate infection

SARS-CoV-2 infection and replication involves the complex interplay of 100+ host and viral proteins and other factors[A,25-32], providing many therapeutic targets for which many existing compounds have known activity. Scientists have predicted that over 9,000 compounds may reduce COVID-19 risk[33], either by directly minimizing infection or

replication, by supporting immune system function, or by minimizing secondary complications.

### Extensive supporting research

*In Silico* studies predict inhibition of SARS-CoV-2 with bromhexine or metabolites via binding to the spike[B,34], $M^{pro}$[C,34], RNA-dependent RNA polymerase[D,34], and TMPRSS2[E,35] proteins. *In Vitro* studies demonstrate inhibition of the TMPRSS2[E,36] and acid sphingomyelinase[F,37] proteins. Bromhexine is a mucolytic agent that helps thin mucus secretions in the respiratory tract and has been shown to have antiviral properties against respiratory viruses. Bromhexine inhibits the expression of TMPRSS2 which plays an important role in SARS-CoV-2 cell entry and replication[35,36,38] and bromhexine metabolite ambroxol inhibits SARS-CoV-2 via inhibition of acid sphingomyelinase in epithelial cells[37].

### Analysis

We analyze all significant controlled studies of bromhexine for COVID-19. Search methods, inclusion criteria, effect extraction criteria (more serious outcomes have priority), all individual study data, PRISMA answers, and statistical methods are detailed in Appendix 1. We present random effects meta-analysis results for all studies, studies within each treatment stage, individual outcomes, peer-reviewed studies, and Randomized Controlled Trials (RCTs).

### Treatment timing

Figure 3 shows stages of possible treatment for COVID-19. Prophylaxis refers to regularly taking medication before becoming sick, in order to prevent or minimize infection. Early Treatment refers to treatment immediately or soon after symptoms appear, while Late Treatment refers to more delayed treatment.

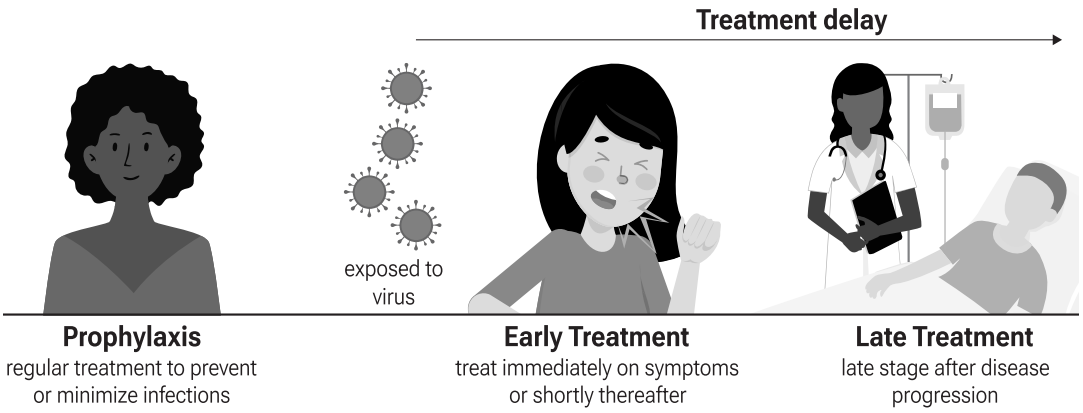



***Figure 3.*** Treatment stages.

## Preclinical Research

*In Silico* studies predict inhibition of SARS-CoV-2 with bromhexine or metabolites via binding to the spike[B,34], $M^{pro}$[C,34], RNA-dependent RNA polymerase[D,34], and TMPRSS2[E,35] proteins. *In Vitro* studies demonstrate inhibition of the TMPRSS2[E,36] and acid sphingomyelinase[F,37] proteins. Bromhexine inhibits the expression of TMPRSS2 which plays an important role in SARS-CoV-2 cell entry and replication[35,36,38] and bromhexine metabolite ambroxol inhibits SARS-CoV-2 via inhibition of acid sphingomyelinase in epithelial cells[37].

2 *In Silico* studies support the efficacy of bromhexine[34,35].

3 *In Vitro* studies support the efficacy of bromhexine[36-38].

Preclinical research is an important part of the development of treatments, however results may be very different in clinical trials. Preclinical results are not used in this paper.

## Results

Table 1 summarizes the results for all stages combined, for Randomized Controlled Trials, for peer-reviewed studies, and for specific outcomes. Table 2 shows results by treatment stage. Figure 4 plots individual results by treatment stage. Figure 5, 6, 7, 8, 9, 10, 11, 12, and 13 show forest plots for random effects meta-analysis of all studies with pooled effects, mortality results, ventilation, ICU admission, hospitalization, recovery, cases, viral clearance, and peer reviewed studies.

| | Relative Risk | Studies | Patients |
|---|---|---|---|
| All studies | 0.57 [0.31-1.05] | 7 | 875 |
| Peer-reviewed | 0.46 [0.21-1.04] | 6 | 503 |
| RCTs | 0.57 [0.31-1.05] | 7 | 875 |
| | | | |
| Mortality | 0.23 [0.04-1.39] | 3 | 550 |
| Hospitalization | 0.90 [0.76-1.08] | 4 | 679 |
| Recovery | 0.54 [0.21-1.39] | 3 | 181 |
| Cases | 0.38 [0.13-1.11] | 2 | 422 |
| Viral | 1.24 [0.66-2.31] | 3 | 321 |
| | | | |
| RCT mortality | 0.23 [0.04-1.39] | 3 | 550 |
| RCT hospitalization | 0.90 [0.76-1.08] | 4 | 679 |

***Table 1.*** **Random effects meta-analysis for all stages combined, for Randomized Controlled Trials, for peer-reviewed studies, and for specific outcomes.** Results show the relative risk with treatment and the 95% confidence interval.

| | Early treatment | Late treatment | Prophylaxis |
|---|---|---|---|
| All studies | 0.16 [0.02-1.35] | 0.56 [0.22-1.48] | 0.35 [0.04-3.12] |
| Peer-reviewed | 0.16 [0.02-1.35] | 0.56 [0.22-1.48] | 0.20 [0.01-3.97] |
| RCTs | 0.16 [0.02-1.35] | 0.56 [0.22-1.48] | 0.35 [0.04-3.12] |
| | | | |
| Mortality | 0.09 [0.01-1.59] | 0.24 [0.01-8.03] | 0.67 [0.04-10.46] |
| Hospitalization | 0.33 [0.01-7.94] | 0.92 [0.77-1.09] | 0.26 [0.05-1.46] |
| Recovery | 0.29 [0.03-2.68] | 0.57 [0.17-1.86] | |
| Cases | | | 0.38 [0.13-1.11] |
| Viral | 1.07 [0.64-1.77] | 0.70 [0.06-8.13] | |
| | | | |
| RCT mortality | 0.09 [0.01-1.59] | 0.24 [0.01-8.03] | 0.67 [0.04-10.46] |
| RCT hospitalization | 0.33 [0.01-7.94] | 0.92 [0.77-1.09] | 0.26 [0.05-1.46] |

***Table 2.*** **Random effects meta-analysis results by treatment stage.** Results show the relative risk with treatment and the 95% confidence interval.

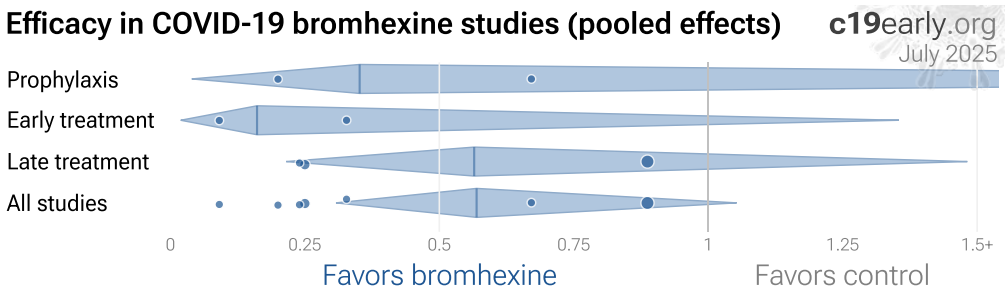



***Figure 4.*** **Scatter plot showing the most serious outcome in all studies, and for studies within each stage.** Diamonds shows the results of random effects meta-analysis.

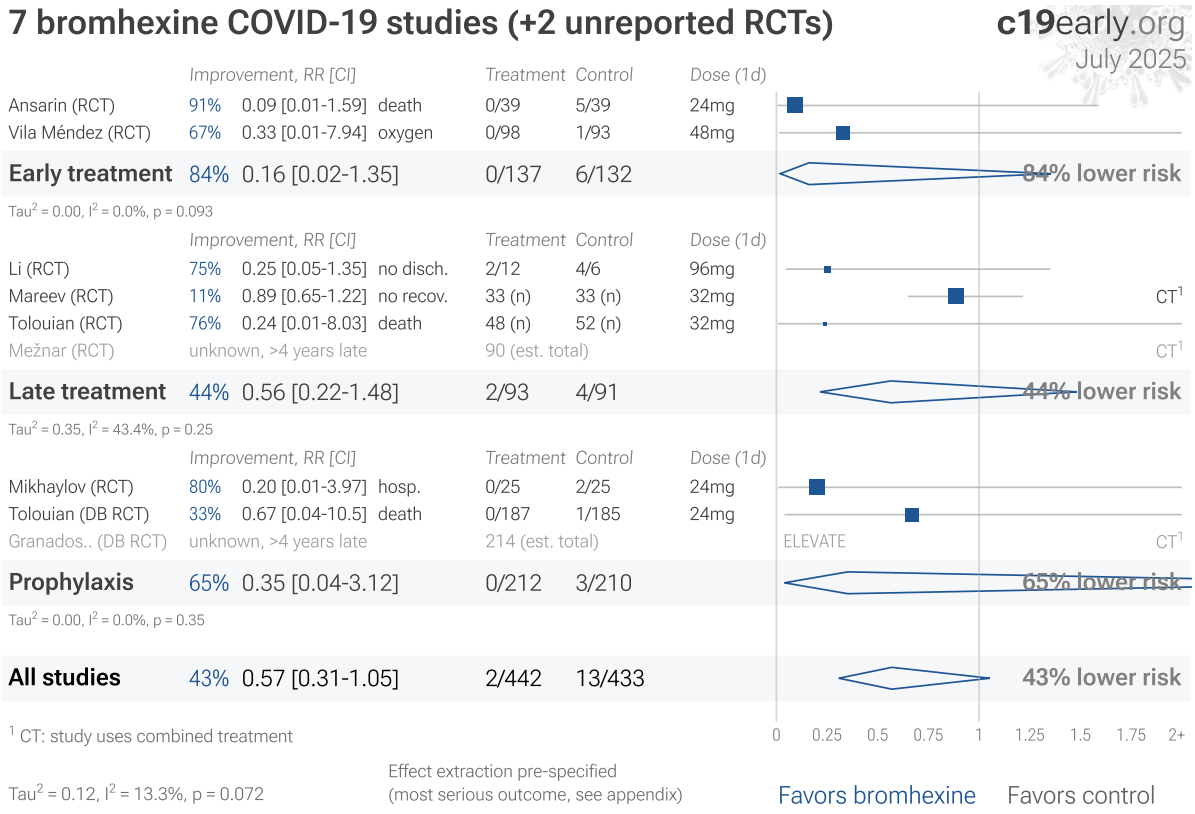



***Figure 5.*** **Random effects meta-analysis for all studies.** This plot shows pooled effects, see the specific outcome analyses for individual outcomes. Analysis validating pooled outcomes for COVID-19 can be found below. Effect extraction is pre-specified, using the most serious outcome reported. For details see the appendix.

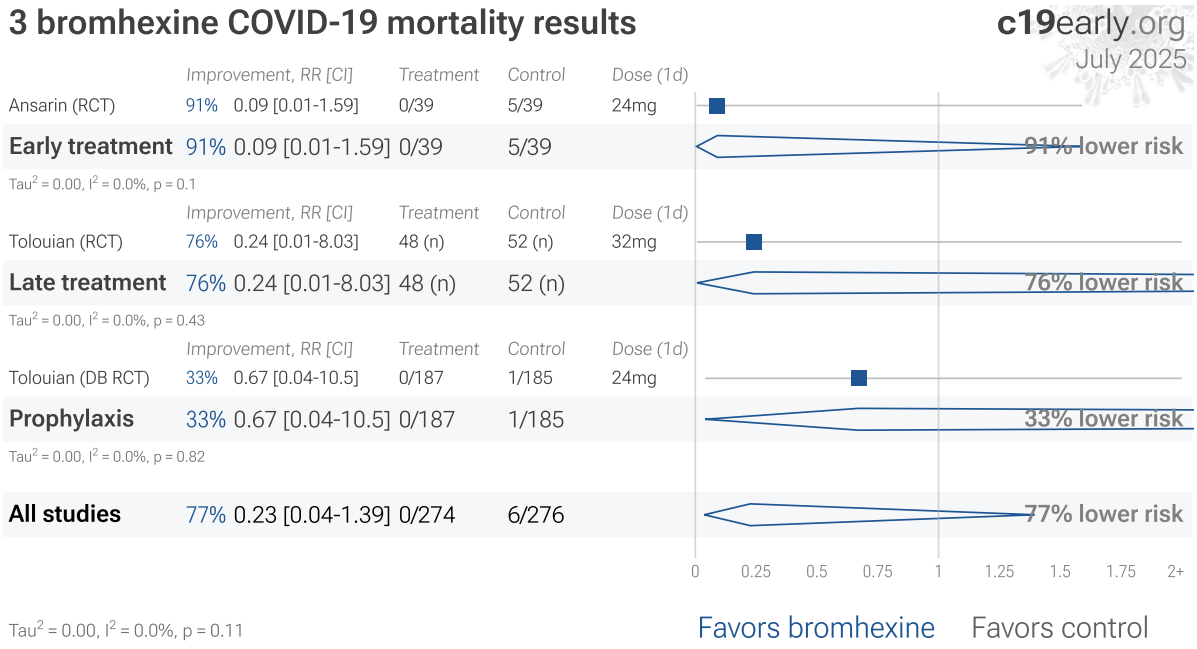



***Figure 6.*** Random effects meta-analysis for mortality results.

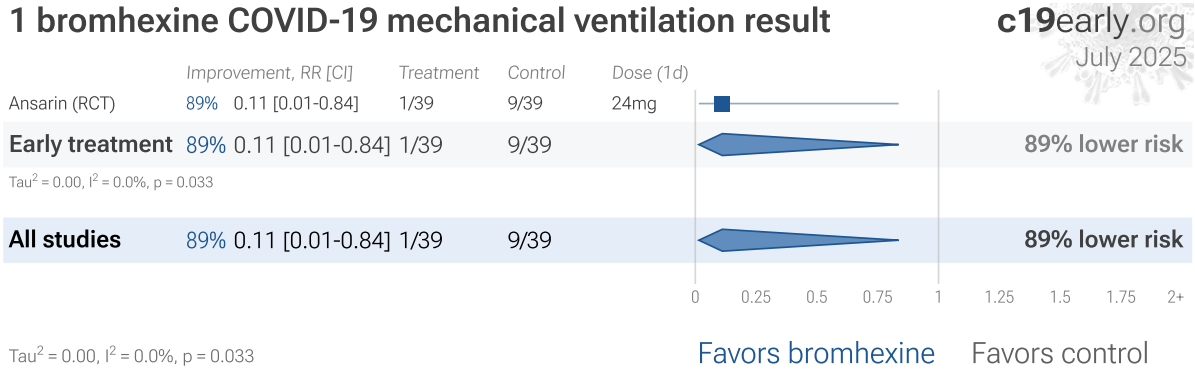



***Figure 7.*** Random effects meta-analysis for ventilation.

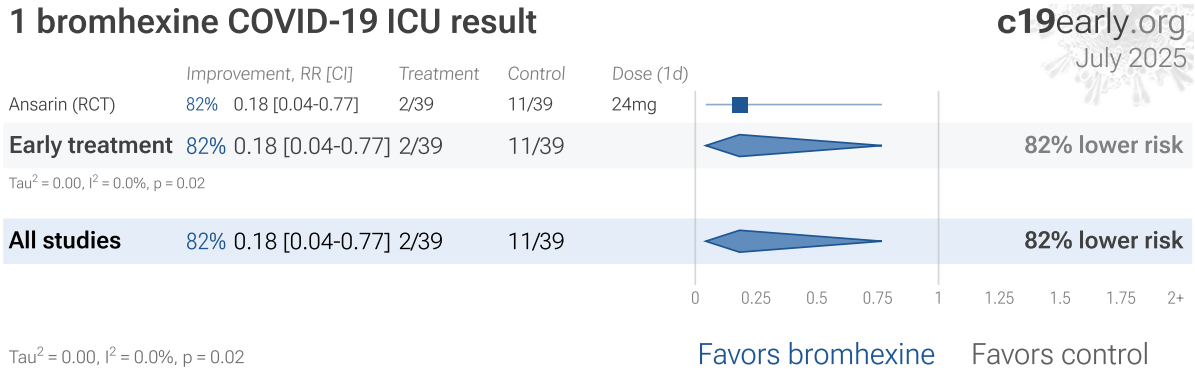



***Figure 8.*** Random effects meta-analysis for ICU admission.

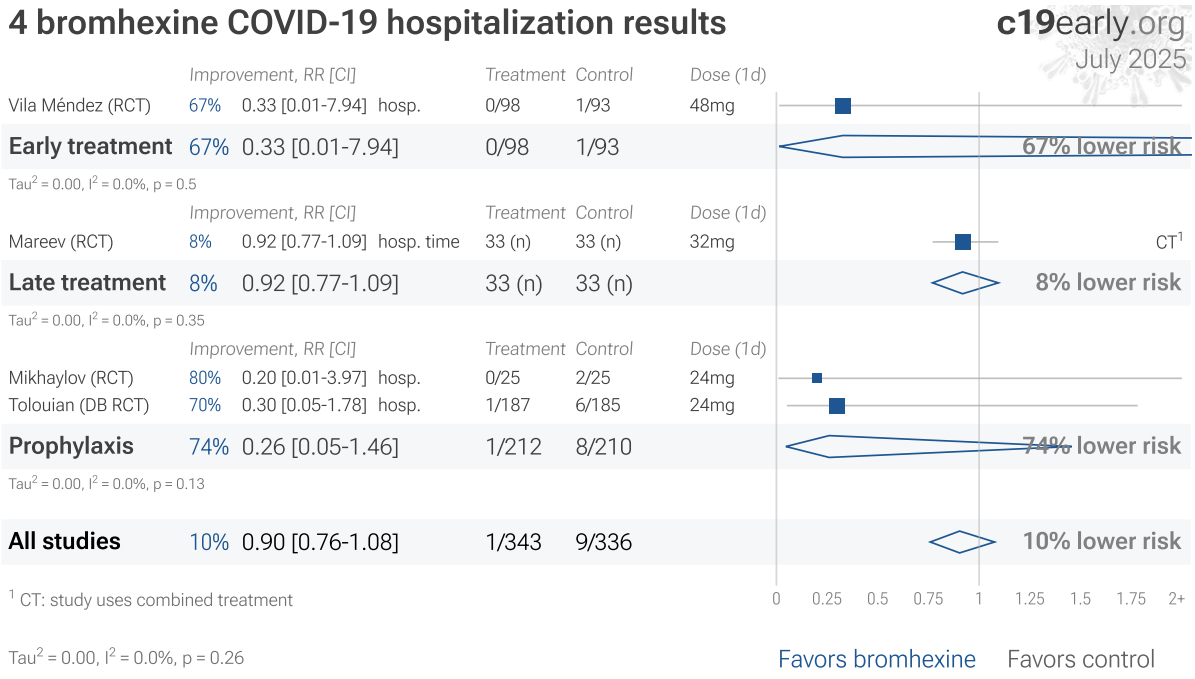



***Figure 9.*** Random effects meta-analysis for hospitalization.

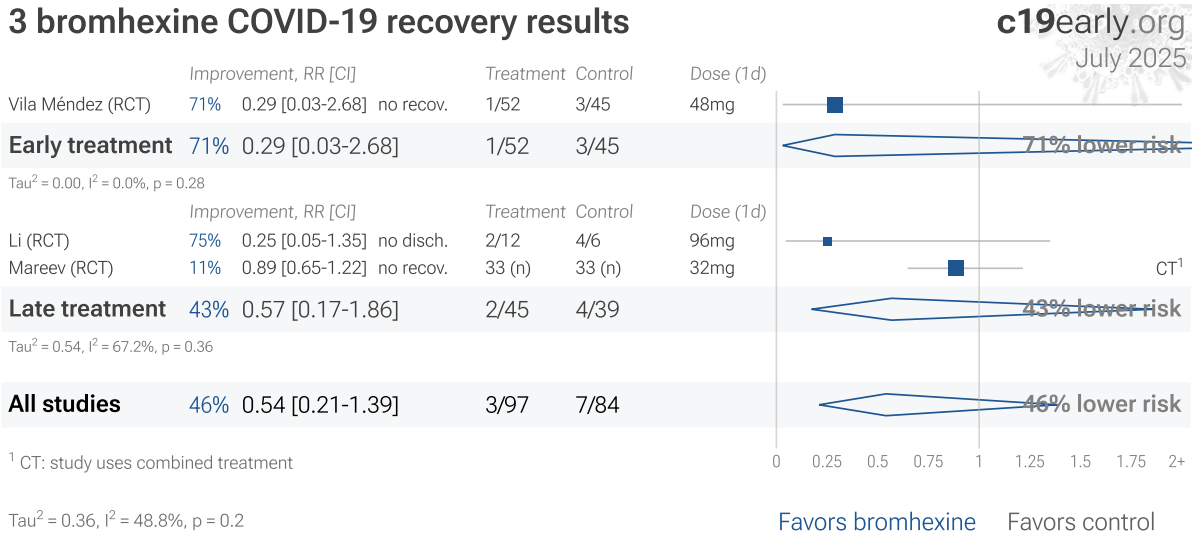



***Figure 10.*** Random effects meta-analysis for recovery.

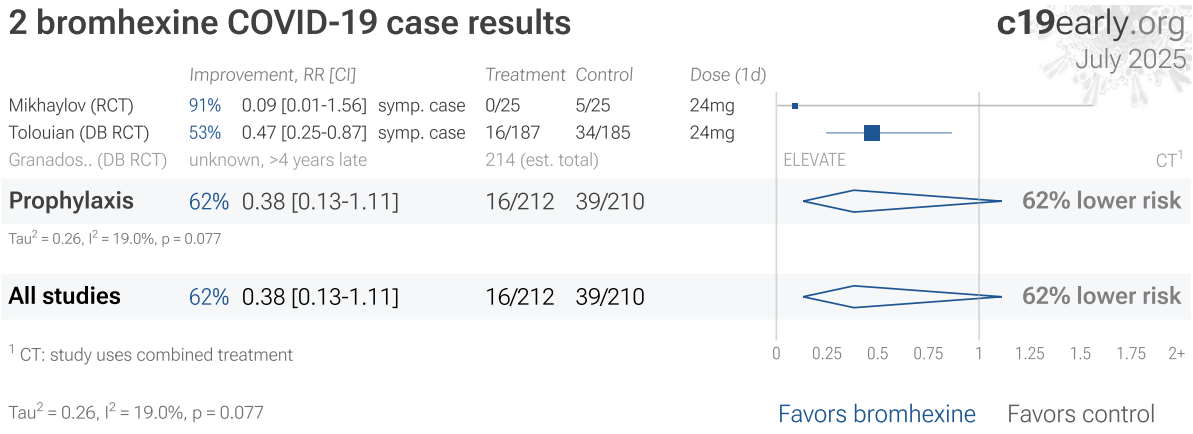



***Figure 11.*** Random effects meta-analysis for cases.

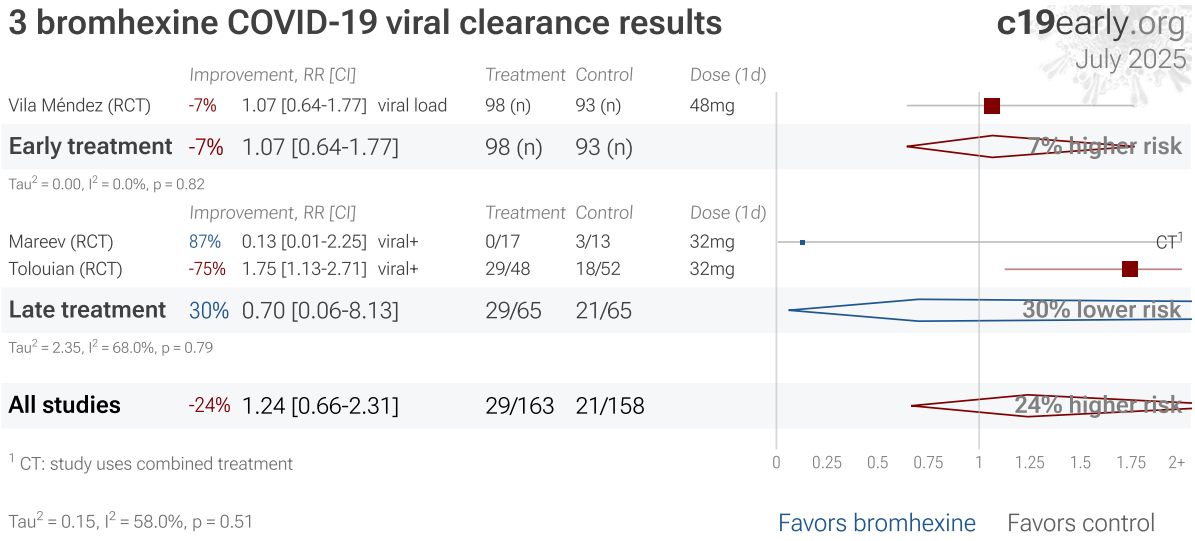



***Figure 12.*** Random effects meta-analysis for viral clearance.

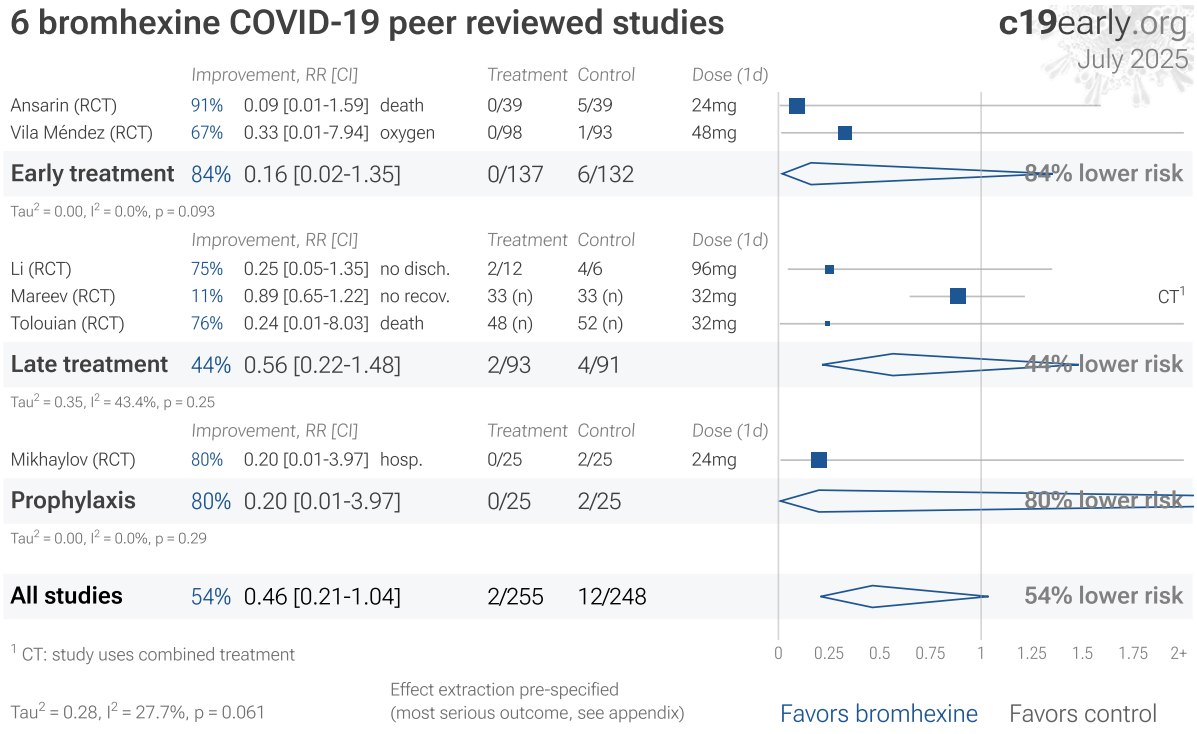



***Figure 13.*** **Random effects meta-analysis for peer reviewed studies.** Effect extraction is pre-specified, using the most serious outcome reported, see the appendix for details. Analysis validating pooled outcomes for COVID-19 can be found below. *Zeraatkar et al.* analyze 356 COVID-19 trials, finding no significant evidence that preprint results are inconsistent with peer-reviewed studies. They also show extremely long peer-review delays, with a median of 6 months to journal publication. A six month delay was equivalent to around 1.5 million deaths during the first two years of the pandemic. Authors recommend using preprint evidence, with appropriate checks for potential falsified data, which provides higher certainty much earlier. *Davidson et al.* also showed no important difference between meta analysis results of preprints and peer-reviewed publications for COVID-19, based on 37 meta analyses including 114 trials.

## Randomized Controlled Trials (RCTs)

Currently all studies are RCTs.

## Unreported RCTs

2 bromhexine RCTs have not reported results [1,2]. The trials report report an estimated total of 304 patients. The results are delayed over 4 years.

## Heterogeneity

Heterogeneity in COVID-19 studies arises from many factors including:

### Treatment delay

The time between infection or the onset of symptoms and treatment may critically affect how well a treatment works. For example an antiviral may be very effective when used early but may not be effective in late stage disease, and may even be harmful. Oseltamivir, for example, is generally only considered effective for influenza when used within 0-36 or 0-48 hours [41,42]. Baloxavir marboxil studies for influenza also show that treatment delay is critical — *Ikematsu et al.*

report an 86% reduction in cases for post-exposure prophylaxis, *Hayden et al.* show a 33 hour reduction in the time to alleviation of symptoms for treatment within 24 hours and a reduction of 13 hours for treatment within 24-48 hours, and *Kumar et al.* report only 2.5 hours improvement for inpatient treatment.

| *Treatment delay* | *Result* |
|---|---|
| Post-exposure prophylaxis | 86% fewer cases [43] |
| <24 hours | -33 hours symptoms [44] |
| 24-48 hours | -13 hours symptoms [44] |
| Inpatients | -2.5 hours to improvement [45] |

***Table 3.*** **Studies of baloxavir marboxil for influenza show that early treatment is more effective.**

Figure 14 shows a mixed-effects meta-regression for efficacy as a function of treatment delay in COVID-19 studies from 172 treatments, showing that efficacy declines rapidly with treatment delay. Early treatment is critical for COVID-19.

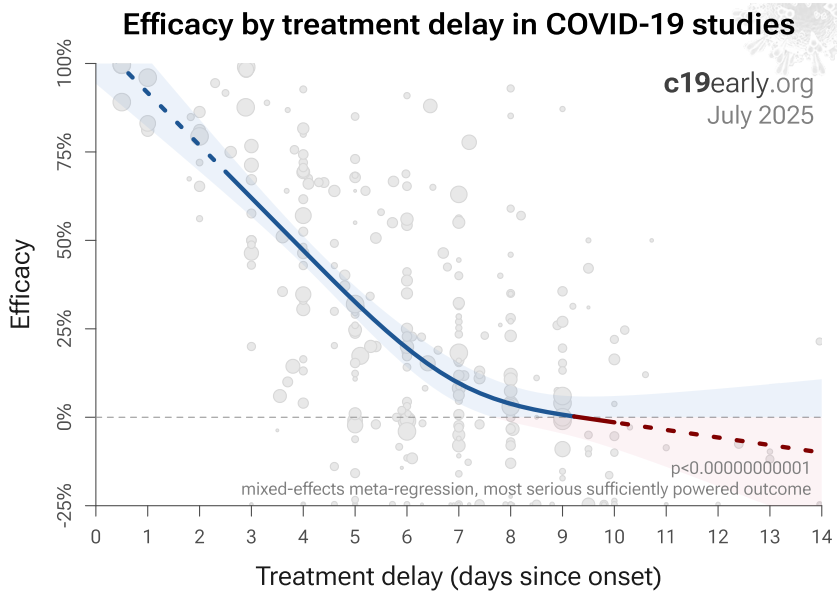



***Figure 14.*** **Early treatment is more effective.** Meta-regression showing efficacy as a function of treatment delay in COVID-19 studies from 172 treatments.

### Patient demographics

Details of the patient population including age and comorbidities may critically affect how well a treatment works. For example, many COVID-19 studies with relatively young low-comorbidity patients show all patients recovering quickly with or without treatment. In such cases, there is little room for an effective treatment to improve results, for example as in *López-Medina et al.*

### SARS-CoV-2 variants

Efficacy may depend critically on the distribution of SARS-CoV-2 variants encountered by patients. Risk varies significantly across variants [47], for example the Gamma variant shows significantly different characteristics [48-51]. Different mechanisms of action may be more or less effective depending on variants, for example the degree to which

TMPRSS2 contributes to viral entry can differ across variants[3,4].

### Treatment regimen

Effectiveness may depend strongly on the dosage and treatment regimen.

### Medication quality

The quality of medications may vary significantly between manufacturers and production batches, which may significantly affect efficacy and safety. *Williams et al.* analyze ivermectin from 11 different sources, showing highly variable antiparasitic efficacy across different manufacturers. *Xu et al.* analyze a treatment from two different manufacturers, showing 9 different impurities, with significantly different concentrations for each manufacturer.

### Other treatments

The use of other treatments may significantly affect outcomes, including supplements, other medications, or other interventions such as prone positioning. Treatments may be synergistic[54-70], therefore efficacy may depend strongly on combined treatments.

### Effect measured

Across all studies there is a strong association between different outcomes, for example improved recovery is strongly associated with lower mortality. However, efficacy may differ depending on the effect measured, for example a treatment may be more effective against secondary complications and have minimal effect on viral clearance.

### Meta analysis

The distribution of studies will alter the outcome of a meta analysis. Consider a simplified example where everything is equal except for the treatment delay, and effectiveness decreases to zero or below with increasing delay. If there are many studies using very late treatment, the outcome may be negative, even though early treatment is very effective. All meta analyses combine heterogeneous studies, varying in population, variants, and potentially all factors above, and therefore may obscure efficacy by including studies where treatment is less effective. Generally, we expect the estimated effect size from meta analysis to be less than that for the optimal case. Looking at all studies is valuable for providing an overview of all research, important to avoid cherry-picking, and informative when a positive result is found despite combining less-optimal situations. However, the resulting estimate does not apply to specific cases such as early treatment in high-risk populations. While we present results for all studies, we also present treatment time and individual outcome analyses, which may be more informative for specific use cases.

## Pooled Effects

### Combining studies is required

For COVID-19, delay in clinical results translates into additional death and morbidity, as well as additional economic and societal damage. Combining the results of studies reporting different outcomes is required. There may be no mortality in a trial with low-risk patients, however a reduction in severity or improved viral clearance may translate into lower mortality in a high-risk population. Different studies may report lower severity, improved recovery, and lower mortality, and the significance may be very high when combining the results. *"The studies reported different outcomes"* is not a good reason for disregarding results. Pooling the results of studies reporting different outcomes allows us to use more of the available information. Logically we should, and do, use additional information when evaluating treatments—for example dose-response and treatment delay-response relationships provide additional evidence of efficacy that is considered when reviewing the evidence for a treatment.

### Specific outcome and pooled analyses

We present both specific outcome and pooled analyses. In order to combine the results of studies reporting different outcomes we use the most serious outcome reported in each study, based on the thesis that improvement in the most serious outcome provides comparable measures of efficacy for a treatment. A critical advantage of this

approach is simplicity and transparency. There are many other ways to combine evidence for different outcomes, along with additional evidence such as dose-response relationships, however these increase complexity.

### Ethical and practical issues limit high-risk trials

Trials with high-risk patients may be restricted due to ethics for treatments that are known or expected to be effective, and they increase difficulty for recruiting. Using less severe outcomes as a proxy for more serious outcomes allows faster and safer collection of evidence.

### Validating pooled outcome analysis for COVID-19

For many COVID-19 treatments, a reduction in mortality logically follows from a reduction in hospitalization, which follows from a reduction in symptomatic cases, which follows from a reduction in PCR positivity. We can directly test this for COVID-19.

Analysis of the the association between different outcomes across studies from all 172 treatments we cover confirms the validity of pooled outcome analysis for COVID-19. Figure 15 shows that lower hospitalization is very strongly associated with lower mortality ($p < 0.000000000001$). Similarly, Figure 16 shows that improved recovery is very strongly associated with lower mortality ($p < 0.000000000001$). Considering the extremes, *Singh et al.* show an association between viral clearance and hospitalization or death, with $p = 0.003$ after excluding one large outlier from a mutagenic treatment, and based on 44 RCTs including 52,384 patients. Figure 17 shows that improved viral clearance is strongly associated with fewer serious outcomes. The association is very similar to *Singh et al.*, with higher confidence due to the larger number of studies. As with *Singh et al.*, the confidence increases when excluding the outlier treatment, from $p = 0.000000082$ to $p = 0.0000000033$.

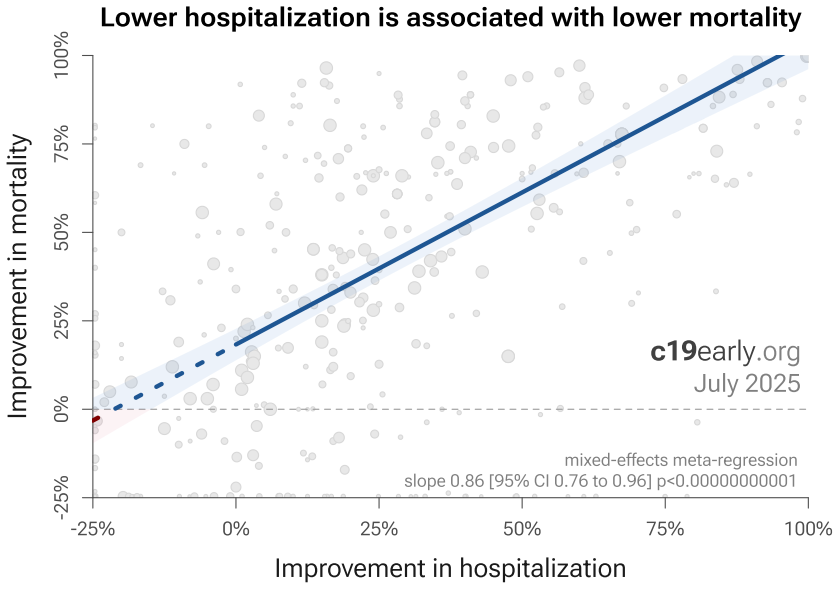



***Figure 15.*** **Lower hospitalization is associated with lower mortality, supporting pooled outcome analysis.**

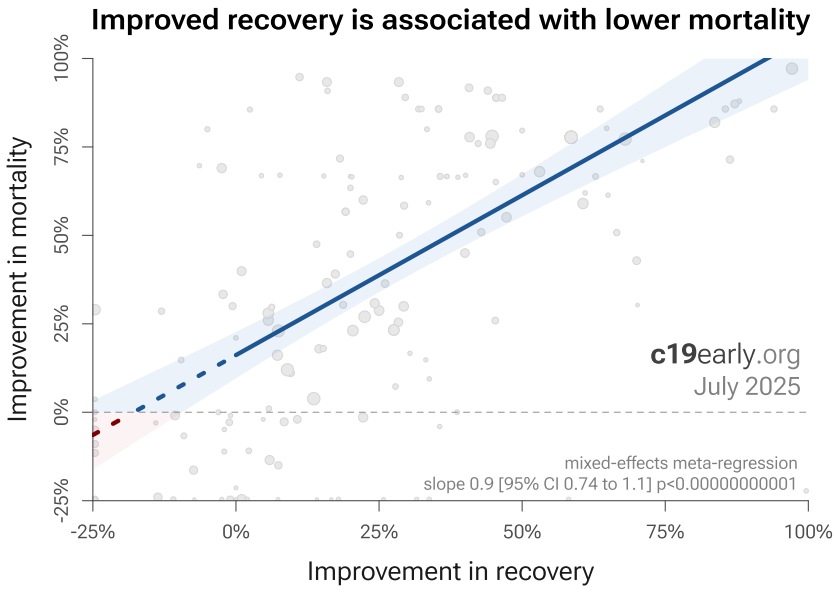



***Figure 16.*** Improved recovery is associated with lower mortality, supporting pooled outcome analysis.

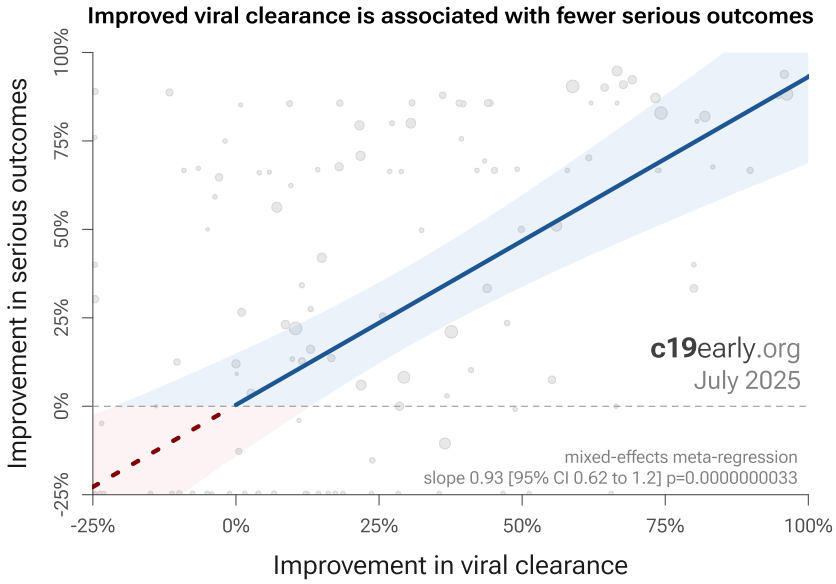



***Figure 15.*** Improved viral clearance is associated with fewer serious outcomes, supporting pooled outcome analysis.

## Pooled outcomes identify efficacy 5 months faster (7 months for RCTs)

Currently, 55 of the treatments we analyze show statistically significant efficacy or harm, defined as ≥10% decreased risk or >0% increased risk from ≥3 studies. 88% of these have been confirmed with one or more specific outcomes, with a mean delay of 4.9 months. When restricting to RCTs only, 57% of treatments showing statistically significant efficacy/harm with pooled effects have been confirmed with one or more specific outcomes, with a mean delay of 7.3 months. Figure 18 shows when treatments were found effective during the pandemic. Pooled outcomes often resulted in earlier detection of efficacy.

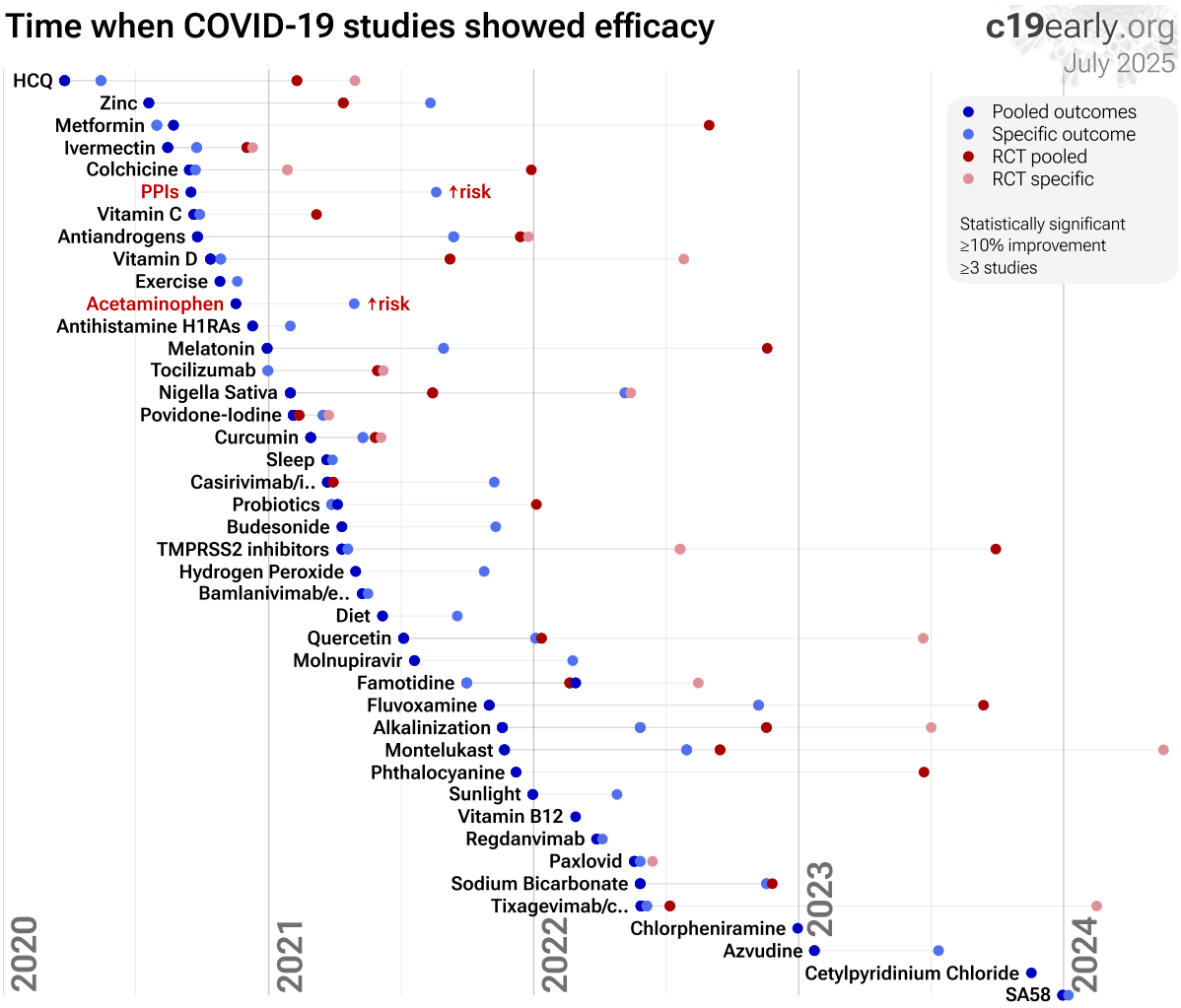



***Figure 18.*** **The time when studies showed that treatments were effective, defined as statistically significant improvement of ≥10% from ≥3 studies.** Pooled results typically show efficacy earlier than specific outcome results. Results from all studies often shows efficacy much earlier than when restricting to RCTs. Results reflect conditions as used in trials to date, these depend on the population treated, treatment delay, and treatment regimen.

### Limitations

Pooled analysis could hide efficacy, for example a treatment that is beneficial for late stage patients but has no effect on viral clearance may show no efficacy if most studies only examine viral clearance. In practice, it is rare for a non-antiviral treatment to report viral clearance and to not report clinical outcomes; and in practice other sources of heterogeneity such as difference in treatment delay is more likely to hide efficacy.

### Summary

Analysis validates the use of pooled effects and shows significantly faster detection of efficacy on average. However, as with all meta analyses, it is important to review the different studies included. We also present individual outcome analyses, which may be more informative for specific use cases.

## Discussion

### Publication bias

Publishing is often biased towards positive results, however evidence suggests that there may be a negative bias for inexpensive treatments for COVID-19. Both negative and positive results are very important for COVID-19, media in many countries prioritizes negative results for inexpensive treatments (inverting the typical incentive for scientists that

value media recognition), and there are many reports of difficulty publishing positive results[72-75]. For bromhexine, there is currently not enough data to evaluate publication bias with high confidence.

### Genetic variants

Genetic variants have been shown to affect COVID-19 infection, severity, and mortality risk[76]. Patients with certain TMPRSS2 variants may potentially benefit more from TMPRSS2 inhibitors like bromhexine[76].

### Funnel plot analysis

Funnel plots have traditionally been used for analyzing publication bias. This is invalid for COVID-19 acute treatment trials — the underlying assumptions are invalid, which we can demonstrate with a simple example. Consider a set of hypothetical perfect trials with no bias. Figure 19 plot A shows a funnel plot for a simulation of 80 perfect trials, with random group sizes, and each patient's outcome randomly sampled (10% control event probability, and a 30% effect size for treatment). Analysis shows no asymmetry (p > 0.05). In plot B, we add a single typical variation in COVID-19 treatment trials — treatment delay. Consider that efficacy varies from 90% for treatment within 24 hours, reducing to 10% when treatment is delayed 3 days. In plot B, each trial's treatment delay is randomly selected. Analysis now shows highly significant asymmetry, $p < 0.0001$, with six variants of Egger's test all showing $p < 0.05$[77-84]. Note that these tests fail even though treatment delay is uniformly distributed. In reality treatment delay is more complex — each trial has a different distribution of delays across patients, and the distribution across trials may be biased (e.g., late treatment trials may be more common). Similarly, many other variations in trials may produce asymmetry, including dose, administration, duration of treatment, differences in SOC, comorbidities, age, variants, and bias in design, implementation, analysis, and reporting.

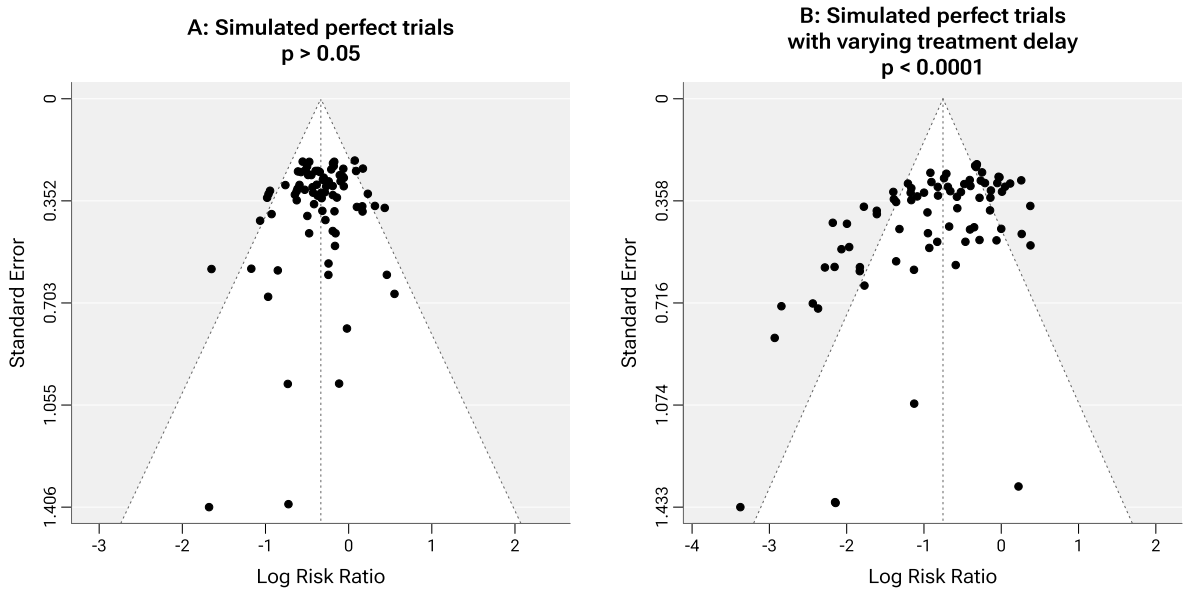



***Figure 19.*** **Example funnel plot analysis for simulated perfect trials.**

### Conflicts of interest

Pharmaceutical drug trials often have conflicts of interest whereby sponsors or trial staff have a financial interest in the outcome being positive. Bromhexine for COVID-19 lacks this because it is off-patent, has multiple manufacturers, and is very low cost. In contrast, most COVID-19 bromhexine trials have been run by physicians on the front lines with the primary goal of finding the best methods to save human lives and minimize the collateral damage caused by COVID-19. While pharmaceutical companies are careful to run trials under optimal conditions (for example, restricting patients to those most likely to benefit, only including patients that can be treated soon after onset when necessary, and ensuring accurate dosing), not all bromhexine trials represent the optimal conditions for efficacy.

## Limitations

Summary statistics from meta analysis necessarily lose information. As with all meta analyses, studies are heterogeneous, with differences in treatment delay, treatment regimen, patient demographics, variants, conflicts of interest, standard of care, and other factors. We provide analyses for specific outcomes and by treatment delay, and we aim to identify key characteristics in the forest plots and summaries. Results should be viewed in the context of study characteristics.

Some analyses classify treatment based on early or late administration, as done here, while others distinguish between mild, moderate, and severe cases. Viral load does not indicate degree of symptoms — for example patients may have a high viral load while being asymptomatic. With regard to treatments that have antiviral properties, timing of treatment is critical — late administration may be less helpful regardless of severity.

Details of treatment delay per patient is often not available. For example, a study may treat 90% of patients relatively early, but the events driving the outcome may come from 10% of patients treated very late. Our 5 day cutoff for early treatment may be too conservative, 5 days may be too late in many cases.

Comparison across treatments is confounded by differences in the studies performed, for example dose, variants, and conflicts of interest. Trials with conflicts of interest may use designs better suited to the preferred outcome.

In some cases, the most serious outcome has very few events, resulting in lower confidence results being used in pooled analysis, however the method is simpler and more transparent. This is less critical as the number of studies increases. Restriction to outcomes with sufficient power may be beneficial in pooled analysis and improve accuracy when there are few studies, however we maintain our pre-specified method to avoid any retrospective changes.

Studies show that combinations of treatments can be highly synergistic and may result in many times greater efficacy than individual treatments alone[54-70]. Therefore standard of care may be critical and benefits may diminish or disappear if standard of care does not include certain treatments.

This real-time analysis is constantly updated based on submissions. Accuracy benefits from widespread review and submission of updates and corrections from reviewers. Less popular treatments may receive fewer reviews.

No treatment or intervention is 100% available and effective for all current and future variants. Efficacy may vary significantly with different variants and within different populations. All treatments have potential side effects. Propensity to experience side effects may be predicted in advance by qualified physicians. We do not provide medical advice. Before taking any medication, consult a qualified physician who can compare all options, provide personalized advice, and provide details of risks and benefits based on individual medical history and situations.

## Notes

3 of 7 studies combine treatments. The results of bromhexine alone may differ. 3 of 7 RCTs use combined treatment.

## Reviews

Multiple reviews cover bromhexine for COVID-19, presenting additional background on mechanisms and related results, including[85-87].

## Other studies

Additional preclinical or review papers suggesting potential benefits of bromhexine for COVID-19 include[96-106]. We have not reviewed these studies in detail.

## Perspective

### Results compared with other treatments

SARS-CoV-2 infection and replication involves a complex interplay of 100+ host and viral proteins and other factors[25-32], providing many therapeutic targets. Over 9,000 compounds have been predicted to reduce COVID-19 risk[33], either by directly minimizing infection or replication, by supporting immune system function, or by minimizing secondary complications. Figure 20 shows an overview of the results for bromhexine in the context of multiple COVID-19 treatments, and Figure 21 shows a plot of efficacy vs. cost for COVID-19 treatments.

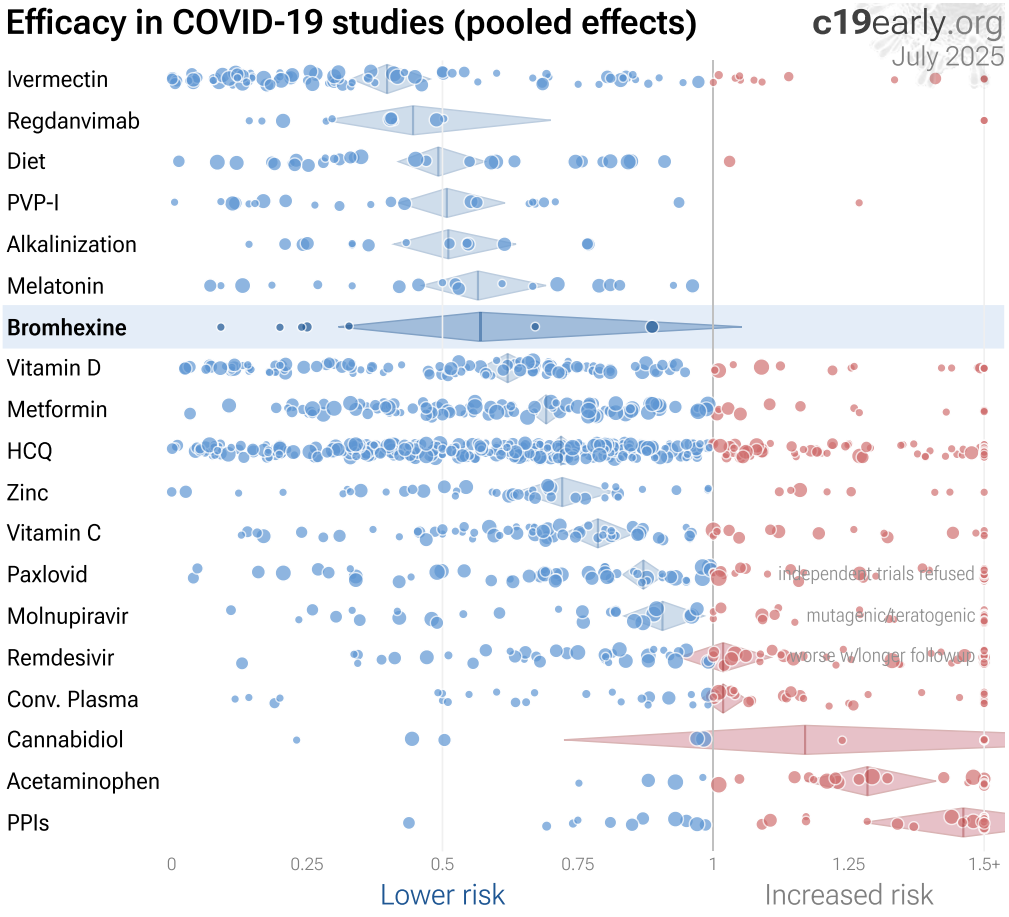



***Figure 20.*** **Scatter plot showing results within the context of multiple COVID-19 treatments.** Diamonds shows the results of random effects meta-analysis. 0.6% of 9,000+ proposed treatments show efficacy[107].

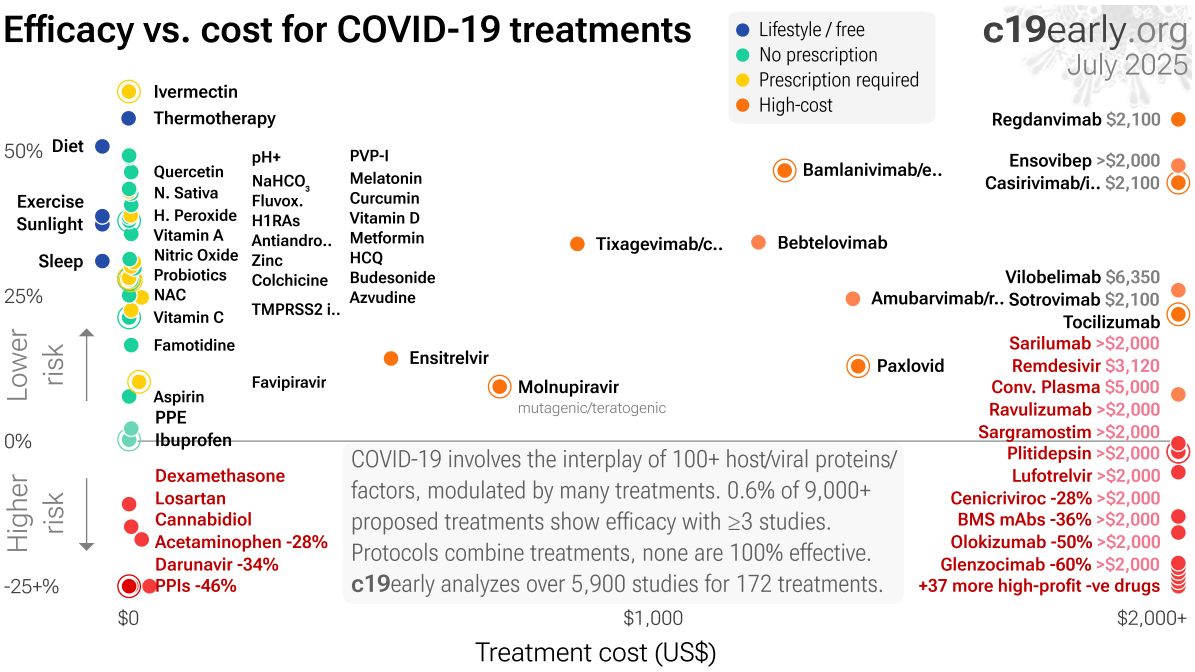



***Figure 21.*** Efficacy vs. cost for COVID-19 treatments.

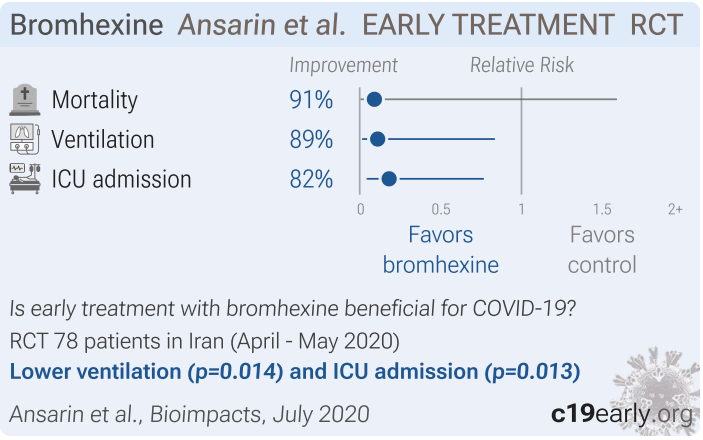
## Conclusion

Significantly lower risk is seen for ventilation and ICU admission. 3 studies from 3 independent teams in 2 countries show significant benefit. Meta analysis using the most serious outcome reported shows 43% [-5-69%] lower risk, without reaching statistical significance. Results are similar for peer-reviewed studies. Early treatment is more effective than late treatment. Currently all studies are RCTs.

Bromhexine efficacy may vary depending on the degree of TMPRSS-dependent fusion for different variants[3,4].

## Study Notes

### Ansarin

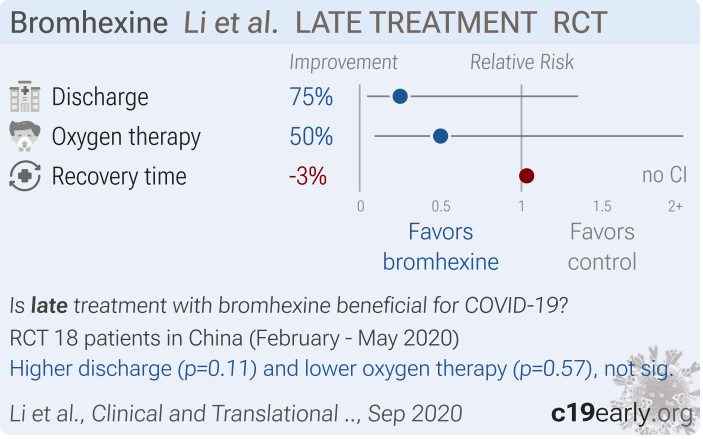



RCT with 39 bromhexine and 39 control patients showing lower mortality, intubation, and ICU admission with treatment. The treatment group received bromhexine hydrochloride 8 mg three times a day for two weeks. All patients received SOC including HCQ.

### Granados-Montiel

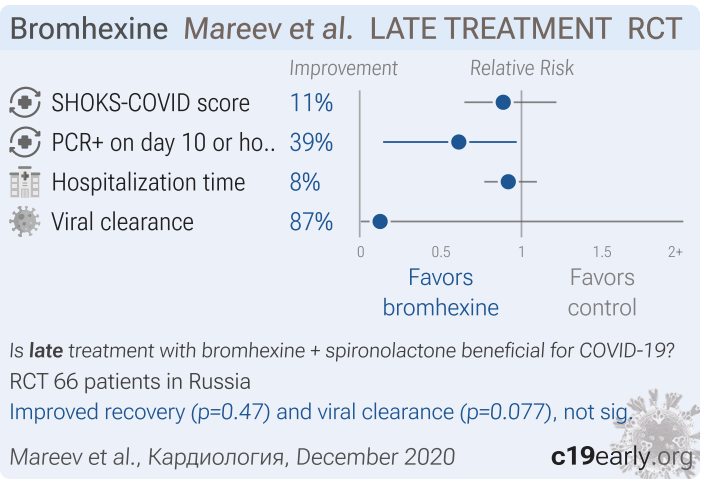
Estimated 214 participant bromhexine + HCQ prophylaxis RCT with results not reported over 4 years after estimated completion.

### Li




Tiny RCT with 12 bromhexine and 6 control patients showing non-statistically significant improvements in chest CT, need for oxygen therapy, and discharge rate within 20 days. Authors recommend a larger scale trial.

### Mareev

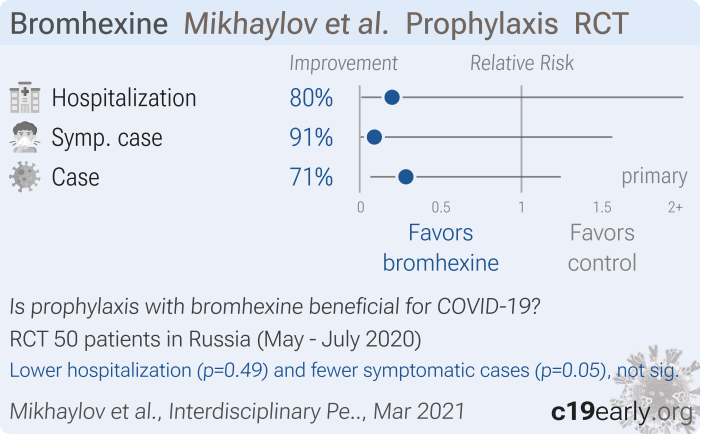



Prospective 103 PCR+ patients in Russia, 33 treated with bromexhine+spironolactone, showing lower PCR+ at day 10 or hospitalization >10 days with treatment. Bromhexine 8mg 4 times daily, spironolactone 25-50 mg/day for 10 days.

### Mežnar

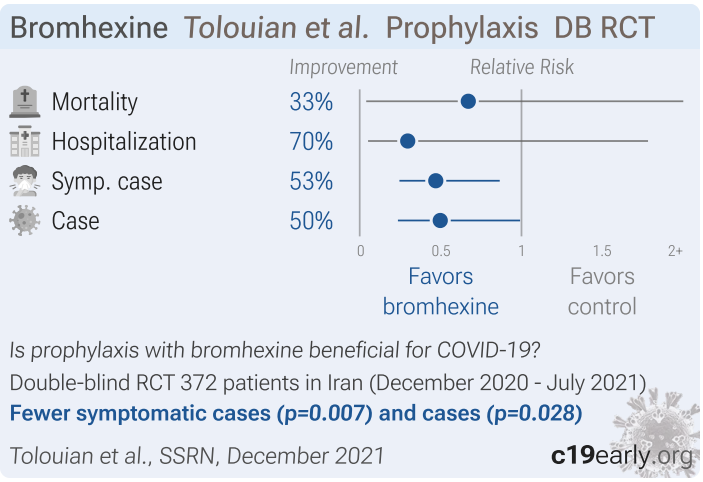
Estimated 90 patient bromhexine + HCQ late treatment RCT with results not reported over 4 years after estimated completion.

### Mikhaylov



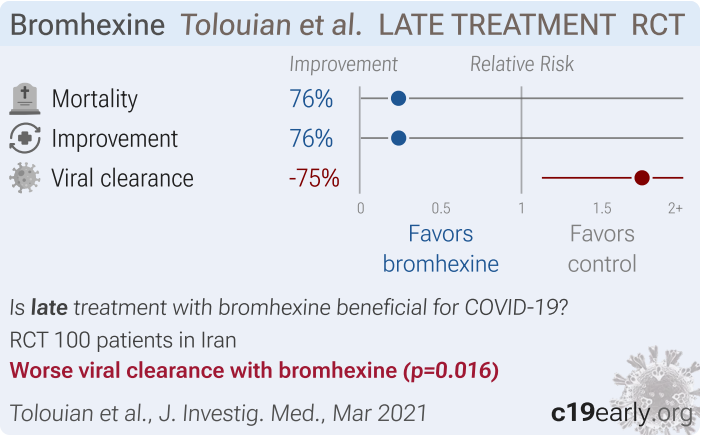

Small prophylaxis RCT with 25 treatment and 25 control health care workers, showing lower PCR+, symptomatic cases, and hospitalization with treatment, although not statistically significant with the small sample size.

### Tolouian




PEP RCT with 372 close contacts of COVID+ patients, 187 treated with bromhexine, showing significantly lower cases with treatment. IRCT20120703010178N22.

### Tolouian

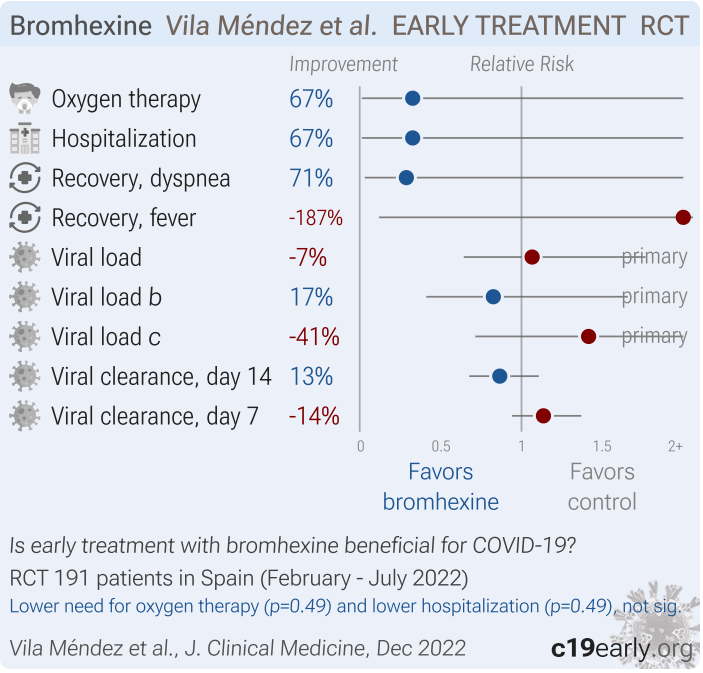


Small RCT with 100 patients, 48 with bromhexine added to SOC, showing slower viral- conversion but lower mortality and greater clinical improvement with bromhexine (not statistically significant with few deaths and very high recovery). The very large difference between unadjusted and adjusted results is due to much higher risk for patients with renal disease and the much higher prevalence of renal disease in the bromhexine group.

The study also shows 90% of patients in the control group had BMI>=30 compared to 0% in the treatment group, suggesting a possible problem with randomization. Due to the imbalance between groups, results were adjusted for BMI>30, smoking, and renal disease.

11 patients were lost to followup in the treatment group compared to zero in the control group, perhaps in part due to faster recovery in the treatment group. 9 patients were excluded from the treatment group because they did not want to take bromhexine after discharge. Therefore up to 29% of treatment patients may have been excluded because they recovered quickly.

### Vila Méndez




RCT 191 low risk (no mortality) outpatients in Spain, showing no significant differences with bromhexine. Authors note that *"statistical differences between the study groups were observed in the percentage of patients treated with bronchodilators (p = 0.033) and receiving symptomatic treatment (p = 0.034), which were higher in the SOC alone group"*, but do not provide details or perform adjustments. There were more moderate/severe cases in the treatment group (9 vs. 5).

Many results appear to be missing including: reduction in the severity of each symptom (0–10 NRS score) at days 4, 7, 14, and 28 as compared with baseline; proportion of patients with clinical improvement and time to clinical improvement; proportion of patients with disappearance of each symptom at days 4, 7, 14, and 28, and time to disappearance; proportion of asymptomatic patients at days 4, 7, 14, and 28.

Bromhexine 48 mg/day for seven days. SOC included acetaminophen.

# Appendix 1. Methods and Data

We perform ongoing searches of PubMed, medRxiv, Europe PMC, ClinicalTrials.gov, The Cochrane Library, Google Scholar, Research Square, ScienceDirect, Oxford University Press, the reference lists of other studies and meta-analyses, and submissions to the site c19early.org. Search terms are bromhexine and COVID-19 or SARS-CoV-2. Automated searches are performed twice daily, with all matches reviewed for inclusion. All studies regarding the use of bromhexine for COVID-19 that report a comparison with a control group are included in the main analysis. Studies with major unexplained data issues, for example major outcome data that is impossible to be correct with no response from the authors, are excluded. This is a living analysis and is updated regularly.

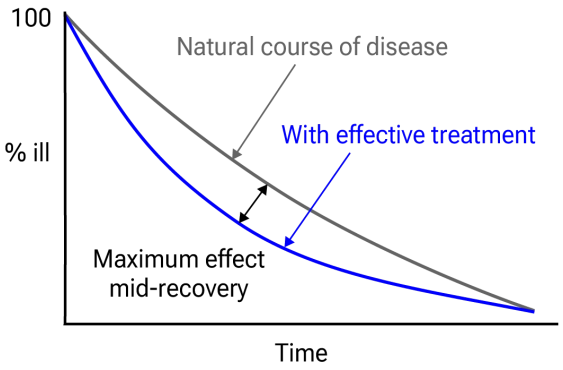



***Figure 22.*** **Mid-recovery results can more accurately reflect efficacy when almost all patients recover.** *Mateja et al.* **confirm that intermediate viral load results more accurately reflect hospitalization/death.**

We extracted effect sizes and associated data from all studies. If studies report multiple kinds of effects then the most serious outcome is used in pooled analysis, while other outcomes are included in the outcome specific analyses. For example, if effects for mortality and cases are reported then they are both used in specific outcome analyses, while mortality is used for pooled analysis. If symptomatic results are reported at multiple times, we use the latest time, for example if mortality results are provided at 14 days and 28 days, the results at 28 days have preference. Mortality alone is preferred over combined outcomes. Outcomes with zero events in both arms are not used, the next most serious outcome with one or more events is used. For example, in low-risk populations with no mortality, a reduction in mortality with treatment is not possible, however a reduction in hospitalization, for example, is still valuable. Clinical outcomes are considered more important than viral outcomes. When basically all patients recover in both treatment and control groups, preference for viral clearance and recovery is given to results mid-recovery where available. After most or all patients have recovered there is little or no room for an effective treatment to do better, however faster recovery is valuable. An IPD meta-analysis confirms that intermediate viral load reduction is more closely associated with hospitalization/death than later viral load reduction [108]. If only individual symptom data is available, the most serious symptom has priority, for example difficulty breathing or low $SpO_2$ is more important than cough. When results provide an odds ratio, we compute the relative risk when possible, or convert to a relative risk according to *Zhang et al.* Reported confidence intervals and *p*-values are used when available, and adjusted values are used when provided. If multiple types of adjustments are reported propensity score matching and multivariable regression has preference over propensity score matching or weighting, which has preference over multivariable regression. Adjusted results have preference over unadjusted results for a more serious outcome when the adjustments significantly alter results. When needed, conversion between reported *p*-values and confidence intervals followed *Altman, Altman (B)*, and Fisher's exact test was used to calculate *p*-values for event data. If continuity correction for zero values is required, we use the reciprocal of the opposite arm with the sum of the correction factors equal to 1 [112]. Results are expressed with RR < 1.0 favoring treatment, and using the risk of a negative outcome when applicable (for example, the risk of death rather than the risk of survival). If studies only report relative continuous values such as relative times, the ratio of the time for the treatment group versus the time for the control group is used. Calculations are done in Python (3.13.5) with scipy (1.16.0), pythonmeta (1.26), numpy (2.3.1), statsmodels (0.14.4), and plotly (6.2.0).

Forest plots are computed using PythonMeta [113] with the DerSimonian and Laird random effects model (the fixed effect assumption is not plausible in this case) and inverse variance weighting. Results are presented with 95% confidence intervals. Heterogeneity among studies was assessed using the $I^2$ statistic. Mixed-effects meta-regression results are computed with R (4.4.0) using the metafor (4.6-0) and rms (6.8-0) packages, and using the most serious sufficiently powered outcome. For all statistical tests, a *p*-value less than 0.05 was considered statistically significant. Grobid 0.8.2 is used to parse PDF documents.

We have classified studies as early treatment if most patients are not already at a severe stage at the time of treatment (for example based on oxygen status or lung involvement), and treatment started within 5 days of the onset of symptoms. If studies contain a mix of early treatment and late treatment patients, we consider the treatment time of patients contributing most to the events (for example, consider a study where most patients are treated early but

late treatment patients are included, and all mortality events were observed with late treatment patients). We note that a shorter time may be preferable. Antivirals are typically only considered effective when used within a shorter timeframe, for example 0-36 or 0-48 hours for oseltamivir, with longer delays not being effective [41,42].

We received no funding, this research is done in our spare time. We have no affiliations with any pharmaceutical companies or political parties.

A summary of study results is below. Please submit updates and corrections at https://c19early.org/bmeta.html.

## Early treatment

Effect extraction follows pre-specified rules as detailed above and gives priority to more serious outcomes. For pooled analyses, the first (most serious) outcome is used, which may differ from the effect a paper focuses on. Other outcomes are used in outcome specific analyses.

| | |
|---|---|
| Ansarin, 7/19/2020, Randomized Controlled Trial, Iran, peer-reviewed, 11 authors, study period 18 April, 2020 - 19 May, 2020. | risk of death, 90.9% lower, RR 0.09, $p = 0.05$, treatment 0 of 39 (0.0%), control 5 of 39 (12.8%), NNT 7.8, relative risk is not 0 because of continuity correction due to zero events (with reciprocal of the contrasting arm). |
| | risk of mechanical ventilation, 88.9% lower, RR 0.11, $p = 0.01$, treatment 1 of 39 (2.6%), control 9 of 39 (23.1%), NNT 4.9. |
| | risk of ICU admission, 81.8% lower, RR 0.18, $p = 0.01$, treatment 2 of 39 (5.1%), control 11 of 39 (28.2%), NNT 4.3. |
| Vila Méndez, 12/24/2022, Randomized Controlled Trial, Spain, peer-reviewed, 38 authors, study period 24 February, 2022 - 28 July, 2022, trial EudraCT2021-001227-41. | risk of oxygen therapy, 67.3% lower, RR 0.33, $p = 0.49$, treatment 0 of 98 (0.0%), control 1 of 93 (1.1%), NNT 93, relative risk is not 0 because of continuity correction due to zero events (with reciprocal of the contrasting arm). |
| | risk of hospitalization, 67.3% lower, RR 0.33, $p = 0.49$, treatment 0 of 98 (0.0%), control 1 of 93 (1.1%), NNT 93, relative risk is not 0 because of continuity correction due to zero events (with reciprocal of the contrasting arm). |
| | risk of no recovery, 71.2% lower, RR 0.29, $p = 0.33$, treatment 1 of 52 (1.9%), control 3 of 45 (6.7%), NNT 21, dyspnea. |
| | risk of no recovery, 186.5% higher, RR 2.87, $p = 1.00$, treatment 1 of 52 (1.9%), control 0 of 45 (0.0%), continuity correction due to zero event (with reciprocal of the contrasting arm), fever. |
| | viral load, 6.6% higher, relative load 1.07, $p = 0.82$, treatment mean 13.54 (±26.02) n=98, control mean 14.43 (±26.94) n=93, relative change in ORF1ab Ct value, day 4, primary outcome. |
| | viral load, 17.4% lower, relative load 0.83, $p = 0.60$, treatment mean 6.36 (±17.05) n=98, control mean 7.7 (±18.47) n=93, relative change in N Ct value, day 4, primary outcome. |
| | viral load, 41.5% higher, relative load 1.41, $p = 0.32$, treatment mean 9.74 (±29.54) n=98, control mean 13.78 (±26.81) n=93, relative change in S Ct value, day 4, primary outcome. |
| | risk of no viral clearance, 13.4% lower, RR 0.87, $p = 0.31$, treatment 52 of 98 (53.1%), control 57 of 93 (61.3%), NNT 12, day 14. |
| | risk of no viral clearance, 13.6% higher, RR 1.14, $p = 0.21$, treatment 73 of 98 (74.5%), control 61 of 93 (65.6%), day 7. |

## Late treatment

Effect extraction follows pre-specified rules as detailed above and gives priority to more serious outcomes. For pooled analyses, the first (most serious) outcome is used, which may differ from the effect a paper focuses on. Other outcomes are used in outcome specific analyses.

| | |
|---|---|
| *Li*, 9/3/2020, Randomized Controlled Trial, China, peer-reviewed, 10 authors, study period 16 February, 2020 - 10 May, 2020, trial NCT04273763 (history). | risk of no hospital discharge, 75.0% lower, RR 0.25, $p = 0.11$, treatment 2 of 12 (16.7%), control 4 of 6 (66.7%), NNT 2.0. |
| | risk of oxygen therapy, 50.0% lower, RR 0.50, $p = 0.57$, treatment 2 of 12 (16.7%), control 2 of 6 (33.3%), NNT 6.0. |
| *Mareev*, 12/3/2020, Randomized Controlled Trial, Russia, peer-reviewed, 20 authors, this trial uses multiple treatments in the treatment arm (combined with spironolactone) - results of individual treatments may vary, trial NCT04424134 (history). | relative SHOKS-COVID score, 11.3% better, RR 0.89, $p = 0.47$, treatment mean 2.12 (±1.39) n=33, control mean 2.39 (±1.59) n=33. |
| | risk of PCR+ on day 10 or hospitalization >10 days, 38.8% lower, RR 0.61, $p = 0.02$, treatment 14 of 24 (58.3%), control 20 of 21 (95.2%), NNT 2.7, odds ratio converted to relative risk. |
| | hospitalization time, 8.2% lower, relative time 0.92, $p = 0.35$, treatment 33, control 33. |
| | risk of no viral clearance, 87.4% lower, RR 0.13, $p = 0.08$, treatment 0 of 17 (0.0%), control 3 of 13 (23.1%), NNT 4.3, relative risk is not 0 because of continuity correction due to zero events (with reciprocal of the contrasting arm), day 10. |
| *Mežnar*, 7/31/2020, Randomized Controlled Trial, this trial uses multiple treatments in the treatment arm (combined with HCQ) - results of individual treatments may vary, trial NCT04355026 (history). | Estimated 90 patient RCT with results unknown and over 4 years late. |
| *Tolouian*, 3/15/2021, Randomized Controlled Trial, Iran, peer-reviewed, 7 authors. | risk of death, 76.0% lower, OR 0.24, $p = 0.43$, treatment 48, control 52, adjusted per study, Table 3, RR approximated with OR. |
| | risk of no improvement, 75.9% better, OR 0.24, $p = 0.43$, treatment 48, control 52, adjusted per study, inverted to make OR<1 favor treatment, Table 2, RR approximated with OR. |
| | risk of no viral clearance, 74.5% higher, RR 1.75, $p = 0.02$, treatment 29 of 48 (60.4%), control 18 of 52 (34.6%), mid-recovery day 7. |

## Prophylaxis

Effect extraction follows pre-specified rules as detailed above and gives priority to more serious outcomes. For pooled analyses, the first (most serious) outcome is used, which may differ from the effect a paper focuses on. Other outcomes are used in outcome specific analyses.

| | |
|---|---|
| *Granados-Montiel*, 6/30/2021, Double Blind Randomized Controlled Trial, placebo-controlled, Mexico, peer-reviewed, this trial uses multiple treatments in the treatment arm (combined with HCQ) - results of individual treatments may vary, trial NCT04340349 (history) (ELEVATE). | Estimated 214 patient RCT with results unknown and over 4 years late. |

| | |
|---|---|
| *Mikhaylov*, 3/8/2021, Randomized Controlled Trial, Russia, peer-reviewed, 8 authors, study period 13 May, 2020 - 25 July, 2020, trial NCT04405999 (history). | **risk of hospitalization, 80.0% lower, RR 0.20, *p* = 0.49**, treatment 0 of 25 (0.0%), control 2 of 25 (8.0%), NNT 12, relative risk is not 0 because of continuity correction due to zero events (with reciprocal of the contrasting arm). |
| | risk of symptomatic case, 90.9% lower, RR 0.09, *p* = 0.05, treatment 0 of 25 (0.0%), control 5 of 25 (20.0%), NNT 5.0, relative risk is not 0 because of continuity correction due to zero events (with reciprocal of the contrasting arm). |
| | risk of case, 71.4% lower, RR 0.29, *p* = 0.14, treatment 2 of 25 (8.0%), control 7 of 25 (28.0%), NNT 5.0, primary outcome. |
| *Tolouian (B)*, 12/20/2021, Double Blind Randomized Controlled Trial, placebo-controlled, Iran, preprint, 16 authors, study period 21 December, 2020 - 25 July, 2021. | **risk of death, 32.9% lower, RR 0.67, *p* = 0.76**, treatment 0 of 187 (0.0%), control 1 of 185 (0.5%), odds ratio converted to relative risk, relative risk is not 0 because of continuity correction due to zero events (with reciprocal of the contrasting arm). |
| | risk of hospitalization, 70.3% lower, RR 0.30, *p* = 0.14, treatment 1 of 187 (0.5%), control 6 of 185 (3.2%), adjusted per study, odds ratio converted to relative risk. |
| | risk of symptomatic case, 53.0% lower, RR 0.47, *p* = 0.007, treatment 16 of 187 (8.6%), control 34 of 185 (18.4%), NNT 10, odds ratio converted to relative risk. |
| | risk of case, 50.2% lower, RR 0.50, *p* = 0.03, treatment 13 of 187 (7.0%), control 26 of 185 (14.1%), NNT 14, odds ratio converted to relative risk. |

## Supplementary Data

Supplementary Data

## Footnotes

a. Viral infection and replication involves attachment, entry, uncoating and release, genome replication and transcription, translation and protein processing, assembly and budding, and release. Each step can be disrupted by therapeutics.

b. The trimeric spike (S) protein is a glycoprotein that mediates viral entry by binding to the host ACE2 receptor, is critical for SARS-CoV-2's ability to infect host cells, and is a target of neutralizing antibodies. Inhibition of the spike protein prevents viral attachment, halting infection at the earliest stage.

c. The main protease or $M^{pro}$, also known as $3CL^{pro}$ or nsp5, is a cysteine protease that cleaves viral polyproteins into functional units needed for replication. Inhibiting $M^{pro}$ disrupts the SARS-CoV-2 lifecycle within the host cell, preventing the creation of new copies.

d. RNA-dependent RNA polymerase (RdRp), also called nsp12, is the core enzyme of the viral replicase-transcriptase complex that copies the positive-sense viral RNA genome into negative-sense templates for progeny RNA synthesis. Inhibiting RdRp blocks viral genome replication and transcription.

e. Transmembrane protease serine 2 (TMPRSS2) is a host cell protease that primes the spike protein, facilitating cellular entry. TMPRSS2 activity helps enable cleavage of the spike protein required for membrane fusion and virus entry. Inhibition may especially protect respiratory epithelial cells, buy may have physiological effects.

f. Acid sphingomyelinase (ASM) is a lysosomal enzyme that hydrolyzes sphingomyelin into ceramide and phosphorylcholine. ASM activity is upregulated by SARS-CoV-2 infection, leading to ceramide-enriched membrane domains that facilitate viral entry and replication. Inhibiting ASM may disrupt viral entry and reduce infection severity while potentially restoring membrane stability and immune homeostasis.

## References


1. **Granados-Montiel** et al., *New prophylaxis regimen for SARS-CoV-2 infection in health professionals with low doses of hydroxychloroquine and bromhexine: a randomised, double-blind placebo clinical trial (ELEVATE Trial)*, BMJ Open, doi:10.1136/bmjopen-2020-045190.
2. **Mežnar** et al., *Use of Bromhexine and Hydroxychloroquine for Treatment of COVID-19 Pneumonia*, NCT04355026, clinicaltrials.gov/study/NCT04355026.
3. **Willett** et al., *The hyper-transmissible SARS-CoV-2 Omicron variant exhibits significant antigenic change, vaccine escape and a switch in cell entry mechanism*, medRxiv, doi:10.1101/2022.01.03.21268111.
4. **Peacock** et al., *The SARS-CoV-2 variant, Omicron, shows rapid replication in human primary nasal epithelial cultures and efficiently uses the endosomal route of entry*, bioRxiv, doi:10.1101/2021.12.31.474653.
5. **Ryu** et al., *Fibrin drives thromboinflammation and neuropathology in COVID-19*, Nature, doi:10.1038/s41586-024-07873-4.
6. **Rong** et al., *Persistence of spike protein at the skull-meninges-brain axis may contribute to the neurological sequelae of COVID-19*, Cell Host & Microbe, doi:10.1016/j.chom.2024.11.007.
7. **Yang** et al., *SARS-CoV-2 infection causes dopaminergic neuron senescence*, Cell Stem Cell, doi:10.1016/j.stem.2023.12.012.
8. **Scardua-Silva** et al., *Microstructural brain abnormalities, fatigue, and cognitive dysfunction after mild COVID-19*, Scientific Reports, doi:10.1038/s41598-024-52005-7.
9. **Hampshire** et al., *Cognition and Memory after Covid-19 in a Large Community Sample*, New England Journal of Medicine, doi:10.1056/NEJMoa2311330.
10. **Duloquin** et al., *Is COVID-19 Infection a Multiorganic Disease? Focus on Extrapulmonary Involvement of SARS-CoV-2*, Journal of Clinical Medicine, doi:10.3390/jcm13051397.
11. **Sodagar** et al., *Pathological Features and Neuroinflammatory Mechanisms of SARS-CoV-2 in the Brain and Potential Therapeutic Approaches*, Biomolecules, doi:10.3390/biom12070971.
12. **Sagar** et al., *COVID-19-associated cerebral microbleeds in the general population*, Brain Communications, doi:10.1093/braincomms/fcae127.
13. **Verma** et al., *Persistent Neurological Deficits in Mouse PASC Reveal Antiviral Drug Limitations*, bioRxiv, doi:10.1101/2024.06.02.596989.
14. **Panagea** et al., *Neurocognitive Impairment in Long COVID: A Systematic Review*, Archives of Clinical Neuropsychology, doi:10.1093/arclin/acae042.
15. **Ariza** et al., *COVID-19: Unveiling the Neuropsychiatric Maze—From Acute to Long-Term Manifestations*, Biomedicines, doi:10.3390/biomedicines12061147.
16. **Vashisht** et al., *Neurological Complications of COVID-19: Unraveling the Pathophysiological Underpinnings and Therapeutic Implications*, Viruses, doi:10.3390/v16081183.
17. **Ahmad** et al., *Neurological Complications and Outcomes in Critically Ill Patients With COVID-19: Results From International Neurological Study Group From the COVID-19 Critical Care Consortium*, The Neurohospitalist, doi:10.1177/19418744241292487.
18. **Wang** et al., *SARS-CoV-2 membrane protein induces neurodegeneration via affecting Golgi-mitochondria interaction*, Translational Neurodegeneration, doi:10.1186/s40035-024-00458-1.
19. **Eberhardt** et al., *SARS-CoV-2 infection triggers pro-atherogenic inflammatory responses in human coronary vessels*, Nature Cardiovascular Research, doi:10.1038/s44161-023-00336-5.
20. **Van Tin** et al., *Spike Protein of SARS-CoV-2 Activates Cardiac Fibrogenesis through NLRP3 Inflammasomes and NF-κB Signaling*, Cells, doi:10.3390/cells13161331.
21. **Borka Balas** et al., *COVID-19 and Cardiac Implications—Still a Mystery in Clinical Practice*, Reviews in Cardiovascular Medicine, doi:10.31083/j.rcm2405125.
22. **AlTaweel** et al., *An In-Depth Insight into Clinical, Cellular and Molecular Factors in COVID19-Associated Cardiovascular Ailments for Identifying Novel Disease Biomarkers, Drug Targets and Clinical Management Strategies*, Archives of Microbiology & Immunology, doi:10.26502/ami.936500177.
23. **Saha** et al., *COVID-19 beyond the lungs: Unraveling its vascular impact and cardiovascular complications—mechanisms and therapeutic implications*, Science Progress, doi:10.1177/00368504251322069.
24. **Trender** et al., *Changes in memory and cognition during the SARS-CoV-2 human challenge study*, eClinicalMedicine, doi:10.1016/j.eclinm.2024.102842.
25. **Dugied** et al., *Multimodal SARS-CoV-2 interactome sketches the virus-host spatial organization*, Communications Biology, doi:10.1038/s42003-025-07933-z.
26. **Malone** et al., *Structures and functions of coronavirus replication–transcription complexes and their relevance for SARS-CoV-2 drug design*, Nature Reviews Molecular Cell Biology, doi:10.1038/s41580-021-00432-z.
27. **Murigneux** et al., *Proteomic analysis of SARS-CoV-2 particles unveils a key role of G3BP proteins in viral assembly*, Nature Communications, doi:10.1038/s41467-024-44958-0.
28. **Lv** et al., *Host proviral and antiviral factors for SARS-CoV-2*, Virus Genes, doi:10.1007/s11262-021-01869-2.
29. **Lui** et al., *Nsp1 facilitates SARS-CoV-2 replication through calcineurin-NFAT signaling*, Virology, doi:10.1128/mbio.00392-24.
30. **Niarakis** et al., *Drug-target identification in COVID-19 disease mechanisms using computational systems biology approaches*, Frontiers in Immunology, doi:10.3389/fimmu.2023.1282859.
31. **Katiyar** et al., *SARS-CoV-2 Assembly: Gaining Infectivity and Beyond*, Viruses, doi:10.3390/v16111648.

32. **Wu** et al., *Decoding the genome of SARS-CoV-2: a pathway to drug development through translation inhibition*, RNA Biology, doi:10.1080/15476286.2024.2433830.

33. **c19early.org**, c19early.org/treatments.html.

34. **Haque** et al., *Exploring potential therapeutic candidates against COVID-19: a molecular docking study*, Discover Molecules, doi:10.1007/s44345-024-00005-5.

35. **Sgrignani** et al., *Computational Identification of a Putative Allosteric Binding Pocket in TMPRSS2*, Frontiers in Molecular Biosciences, doi:10.3389/fmolb.2021.666626.

36. **Martins** et al., *In Vitro Inhibition of SARS-CoV-2 Infection by Bromhexine hydrochloride*, bioRxiv, doi:10.1101/2022.12.23.521817.

37. **Carpinteiro** et al., *Inhibition of acid sphingomyelinase by ambroxol prevents SARS-CoV-2 entry into epithelial cells*, Journal of Biological Chemistry, doi:10.1016/j.jbc.2021.100701.

38. **Hoffman** et al., *SARS-CoV-2 Cell Entry Depends on ACE2 and TMPRSS2 and Is Blocked by a Clinically Proven Protease Inhibitor*, Cell, doi:10.1016/j.cell.2020.02.052.

39. **Zeraatkar** et al., *Consistency of covid-19 trial preprints with published reports and impact for decision making: retrospective review*, BMJ Medicine, doi:10.1136/bmjmed-2022-0003091.

40. **Davidson** et al., *No evidence of important difference in summary treatment effects between COVID-19 preprints and peer-reviewed publications: a meta-epidemiological study*, Journal of Clinical Epidemiology, doi:10.1016/j.jclinepi.2023.08.011.

41. **Treanor** et al., *Efficacy and Safety of the Oral Neuraminidase Inhibitor Oseltamivir in Treating Acute Influenza: A Randomized Controlled Trial*, JAMA, 2000, 283:8, 1016-1024, doi:10.1001/jama.283.8.1016.

42. **McLean** et al., *Impact of Late Oseltamivir Treatment on Influenza Symptoms in the Outpatient Setting: Results of a Randomized Trial*, Open Forum Infect. Dis. September 2015, 2:3, doi:10.1093/ofid/ofv100.

43. **Ikematsu** et al., *Baloxavir Marboxil for Prophylaxis against Influenza in Household Contacts*, New England Journal of Medicine, doi:10.1056/NEJMoa1915341.

44. **Hayden** et al., *Baloxavir Marboxil for Uncomplicated Influenza in Adults and Adolescents*, New England Journal of Medicine, doi:10.1056/NEJMoa1716197.

45. **Kumar** et al., *Combining baloxavir marboxil with standard-of-care neuraminidase inhibitor in patients hospitalised with severe influenza (FLAGSTONE): a randomised, parallel-group, double-blind, placebo-controlled, superiority trial*, The Lancet Infectious Diseases, doi:10.1016/S1473-3099(21)00469-2.

46. **López-Medina** et al., *Effect of Ivermectin on Time to Resolution of Symptoms Among Adults With Mild COVID-19: A Randomized Clinical Trial*, JAMA, doi:10.1001/jama.2021.3071.

47. **Korves** et al., *SARS-CoV-2 Genetic Variants and Patient Factors Associated with Hospitalization Risk*, medRxiv, doi:10.1101/2024.03.08.24303818.

48. **Faria** et al., *Genomics and epidemiology of the P.1 SARS-CoV-2 lineage in Manaus, Brazil*, Science, doi:10.1126/science.abh2644.

49. **Nonaka** et al., *SARS-CoV-2 variant of concern P.1 (Gamma) infection in young and middle-aged patients admitted to the intensive care units of a single hospital in Salvador, Northeast Brazil, February 2021*, International Journal of Infectious Diseases, doi:10.1016/j.ijid.2021.08.003.

50. **Karita** et al., *Trajectory of viral load in a prospective population-based cohort with incident SARS-CoV-2 G614 infection*, medRxiv, doi:10.1101/2021.08.27.21262754.

51. **Zavascki** et al., *Advanced ventilatory support and mortality in hospitalized patients with COVID-19 caused by Gamma (P.1) variant of concern compared to other lineages: cohort study at a reference center in Brazil*, Research Square, doi:10.21203/rs.3.rs-910467/v1.

52. **Williams**, T., *Not All Ivermectin Is Created Equal: Comparing The Quality of 11 Different Ivermectin Sources*, Do Your Own Research, doyourownresearch.substack.com/p/not-all-ivermectin-is-created-equal.

53. **Xu** et al., *A study of impurities in the repurposed COVID-19 drug hydroxychloroquine sulfate by UHPLC-Q/TOF-MS and LC-SPE-NMR*, Rapid Communications in Mass Spectrometry, doi:10.1002/rcm.9358.

54. **Jitobaom** et al., *Favipiravir and Ivermectin Showed in Vitro Synergistic Antiviral Activity against SARS-CoV-2*, Research Square, doi:10.21203/rs.3.rs-941811/v1.

55. **Jitobaom (B)** et al., *Synergistic anti-SARS-CoV-2 activity of repurposed anti-parasitic drug combinations*, BMC Pharmacology and Toxicology, doi:10.1186/s40360-022-00580-8.

56. **Jeffreys** et al., *Remdesivir-ivermectin combination displays synergistic interaction with improved in vitro activity against SARS-CoV-2*, International Journal of Antimicrobial Agents, doi:10.1016/j.ijantimicag.2022.106542.

57. **Ostrov** et al., *Highly Specific Sigma Receptor Ligands Exhibit Anti-Viral Properties in SARS-CoV-2 Infected Cells*, Pathogens, doi:10.3390/pathogens10111514.

58. **Alsaidi** et al., *Griffithsin and Carrageenan Combination Results in Antiviral Synergy against SARS-CoV-1 and 2 in a Pseudoviral Model*, Marine Drugs, doi:10.3390/md19080418.

59. **Andreani** et al., *In vitro testing of combined hydroxychloroquine and azithromycin on SARS-CoV-2 shows synergistic effect*, Microbial Pathogenesis, doi:10.1016/j.micpath.2020.104228.

60. **De Forni** et al., *Synergistic drug combinations designed to fully suppress SARS-CoV-2 in the lung of COVID-19 patients*, PLoS ONE, doi:10.1371/journal.pone.0276751.

61. **Wan** et al., *Synergistic inhibition effects of andrographolide and baicalin on coronavirus mechanisms by downregulation of ACE2 protein level*, Scientific Reports, doi:10.1038/s41598-024-54722-5.

62. **Said** et al., *The effect of Nigella sativa and vitamin D3 supplementation on the clinical outcome in COVID-19 patients: A randomized controlled clinical trial*, Frontiers in Pharmacology, doi:10.3389/fphar.2022.1011522.

63. **Fiaschi** et al., *In Vitro Combinatorial Activity of Direct Acting Antivirals and Monoclonal Antibodies against the Ancestral B.1 and BQ.1.1 SARS-CoV-2 Viral Variants*, Viruses, doi:10.3390/v16020168.

64. **Xing** et al., *Published anti-SARS-CoV-2 in vitro hits share common mechanisms of action that synergize with antivirals*, Briefings in Bioinformatics, doi:10.1093/bib/bbab249.

65. **Chen** et al., *Synergistic Inhibition of SARS-CoV-2 Replication Using Disulfiram/Ebselen and Remdesivir*, ACS Pharmacology & Translational Science, doi:10.1021/acsptsci.1c00022.

66. **Hempel** et al., *Synergistic inhibition of SARS-CoV-2 cell entry by otamixaban and covalent protease inhibitors: pre-clinical assessment of pharmacological and molecular properties*, Chemical Science, doi:10.1039/D1SC01494C.

67. **Schultz** et al., *Pyrimidine inhibitors synergize with nucleoside analogues to block SARS-CoV-2*, Nature, doi:10.1038/s41586-022-04482-x.

68. **Ohashi** et al., *Potential anti-COVID-19 agents, cepharanthine and nelfinavir, and their usage for combination treatment*, iScience, doi:10.1016/j.isci.2021.102367.

69. **Al Krad** et al., *The protease inhibitor Nirmatrelvir synergizes with inhibitors of GRP78 to suppress SARS-CoV-2 replication*, bioRxiv, doi:10.1101/2025.03.09.642200.

70. **Thairu** et al., *A Comparison of Ivermectin and Non Ivermectin Based Regimen for COVID-19 in Abuja: Effects on Virus Clearance, Days-to-discharge and Mortality*, Journal of Pharmaceutical Research International, doi:10.9734/jpri/2022/v34i44A36328.

71. **Singh** et al., *The relationship between viral clearance rates and disease progression in early symptomatic COVID-19: a systematic review and meta-regression analysis*, Journal of Antimicrobial Chemotherapy, doi:10.1093/jac/dkae045.

72. **Meneguesso**, A., *Médica defende tratamento precoce da Covid-19*, www.youtube.com/watch?v=X5FCrIm_19U.

73. **Boulware**, D., *Comments regarding paper rejection*, twitter.com/boulware_dr/status/1311331372884205570.

74. **Meeus**, G., *Online Comment*, twitter.com/gertmeeus_MD/status/1386636373889781761.

75. **twitter.com**, twitter.com/KashPrime/status/1768487878454124914.

76. **Ren** et al., *Association of genetic polymorphisms with COVID-19 infection and outcomes: An updated meta-analysis based on 62 studies*, Heliyon, doi:10.1016/j.heliyon.2023.e23662.

77. **Rothstein**, H., *Publication Bias in Meta-Analysis: Prevention, Assessment and Adjustments*, www.wiley.com/en-ae/Publication+Bias+in+Meta+Analysis:+Prevention,+Assessment+and+Adjustments-p-9780470870143.

78. **Stanley** et al., *Meta-regression approximations to reduce publication selection bias*, Research Synthesis Methods, doi:10.1002/jrsm.1095.

79. **Rücker** et al., *Arcsine test for publication bias in meta-analyses with binary outcomes*, Statistics in Medicine, doi:10.1002/sim.2971.

80. **Peters**, J., *Comparison of Two Methods to Detect Publication Bias in Meta-analysis*, JAMA, doi:10.1001/jama.295.6.676.

81. **Moreno** et al., *Assessment of regression-based methods to adjust for publication bias through a comprehensive simulation study*, BMC Medical Research Methodology, doi:10.1186/1471-2288-9-2.

82. **Macaskill** et al., *A comparison of methods to detect publication bias in meta-analysis*, Statistics in Medicine, doi:10.1002/sim.698.

83. **Egger** et al., *Bias in meta-analysis detected by a simple, graphical test*, BMJ, doi:10.1136/bmj.315.7109.629.

84. **Harbord** et al., *A modified test for small-study effects in meta-analyses of controlled trials with binary endpoints*, Statistics in Medicine, doi:10.1002/sim.2380.

85. **Mitev**, V., *Comparison of treatment of COVID-19 with inhaled bromhexine, higher doses of colchicine and hymecromone with WHO-recommended paxlovid, molnupiravir, remdesivir, anti-IL-6 receptor antibodies and baricitinib*, Pharmacia, doi:10.3897/pharmacia.70.e112550.

86. **Al-Kuraishy** et al., *The potential role of Bromhexine in the management of COVID-19: Decipher and a real game-changer*, Current Medical and Drug Research, www.researchgate.net/publication/347446399_The_potential_role_of_Bromhexine_in_the_management_of_COVID-19_Decipher_and_a_real_game-changer.

87. **Maggio** et al., *Repurposing the mucolytic cough suppressant and TMPRSS2 protease inhibitor bromhexine for the prevention and management of SARS-CoV-2 infection*, Pharmacol Res., doi:10.1016/j.phrs.2020.104837.

88. **Ghayour** et al., *Evaluation of the recovery rate and prevention of hospitalization among covid-19 outpatients: a randomized clinical trial comparing N-acetylcysteine with Bromhexine*, Research Square, doi:10.21203/rs.3.rs-2309373/v2.

89. **Vila Méndez** et al., *Efficacy of Bromhexine versus Standard of Care in Reducing Viral Load in Patients with Mild-to-Moderate COVID-19 Disease Attended in Primary Care: A Randomized Open-Label Trial*, Journal of Clinical Medicine, doi:10.3390/jcm12010142.

90. **Ansarin** et al., *Effect of bromhexine on clinical outcomes and mortality in COVID-19 patients: A randomized clinical trial*, Bioimpacts, doi:10.34172/bi.2020.27.

91. **Tolouian** et al., *Effect of bromhexine in hospitalized patients with COVID-19*, J. Investig. Med., doi:10.1136/jim-2020-001747.

92. **Mareev** et al., *Results of Open-Label non-Randomized Comparative Clinical Trial: "BromhexIne and Spironolactone for CoronavirUs Infection requiring hospiTalization (BISCUIT)*, Кардиология, doi:10.18087/cardio.2020.11.n1440.

93. **Li** et al., *Bromhexine Hydrochloride Tablets for the Treatment of Moderate COVID-19: An Open-Label Randomized Controlled Pilot Study*, Clinical and Translational Science, doi:10.1111/cts.12881.

94. **Tolouian (B)** et al., *Bromhexine, for Post Exposure COVID-19 Prophylaxis: A Randomized, Double-Blind, Placebo Control Trial*, SSRN, doi:10.2139/ssrn.3989.

95. **Mikhaylov** et al., *Bromhexine Hydrochloride Prophylaxis of COVID-19 for Medical Personnel: A Randomized Open-Label Study*, Interdisciplinary Perspectives on Infectious Diseases, doi:10.1155/2022/4693121.

96. **Baby** et al., *Exploring TMPRSS2 Drug Target to Combat Influenza and Coronavirus Infection*, Scientifica, doi:10.1155/sci5/3687892.

97. **Chowdhury** et al., *Exploring Natural Plant Compounds Against the SARS-CoV-2 Spike Protein: An Analytical and Computational Approach for Drug Discovery*, Pharmacological Research - Natural Products, doi:10.1016/j.prenap.2025.100191.

98. **Saini** et al., *The Potential of Drug Repurposing as a Rapid Response Strategy in COVID-19 Therapeutics*, Journal of Advances in Medical and Pharmaceutical Sciences, doi:10.9734/jamps/2024/v26i12728.

99. **Sharma** et al., *Reviewing the insights of SARS-CoV-2: Its Epidemiology, Pathophysiology, and Potential Preventive Measures in Traditional Medicinal System*, Clinical Traditional Medicine and Pharmacology, doi:10.1016/j.ctmp.2024.200147.

100. **Ku** et al., *Repurposing Screens of FDA-Approved Drugs Identify 29 Inhibitors of SARS-CoV-2*, Journal of Microbiology and Biotechnology, doi:10.4014/jmb.2009.09009.

101. **Lan** et al., *Clinical development of antivirals against SARS-CoV-2 and its variants*, Current Research in Microbial Sciences, doi:10.1016/j.crmicr.2023.100208.

102. **Yadav** et al., *Role of Structural and Non-Structural Proteins and Therapeutic Targets of SARS-CoV-2 for COVID-19*, Cells, doi:10.3390/cells10040821.

103. **Lundstrom** et al., *COVID-19 signalome: Potential therapeutic interventions*, Cellular Signalling, doi:10.1016/j.cellsig.2022.110559.

104. **Oliver** et al., *Different drug approaches to COVID-19 treatment worldwide: an update of new drugs and drugs repositioning to fight against the novel coronavirus*, Therapeutic Advances in Vaccines and Immunotherapy, doi:10.1177/25151355221144845.

105. **Mitev (B)** et al., *Colchicine, Bromhexine, and Hymecromone as Part of COVID-19 Treatment-Cold, Warm, Hot*, Current Overview on Disease and Health Research Vol. 10, doi:10.9734/bpi/codhr/v10/5310A.

106. **Kumar (B)** et al., *COVID-19 therapeutics: Clinical application of repurposed drugs and futuristic strategies for target-based drug discovery*, Genes & Diseases, doi:10.1016/j.gendis.2022.12.019.

107. **c19early.org (B)**, c19early.org/timeline.html.

108. **Mateja** et al., *The choice of viral load endpoint in early phase trials of COVID-19 treatments aiming to reduce 28-day hospitalization and/or death*, The Journal of Infectious Diseases, doi:10.1093/infdis/jiaf282.

109. **Zhang** et al., *What's the relative risk? A method of correcting the odds ratio in cohort studies of common outcomes*, JAMA, 80:19, 1690, doi:10.1001/jama.280.19.1690.

110. **Altman**, D., *How to obtain the P value from a confidence interval*, BMJ, doi:10.1136/bmj.d2304.

111. **Altman (B)** et al., *How to obtain the confidence interval from a P value*, BMJ, doi:10.1136/bmj.d2090.

112. **Sweeting** et al., *What to add to nothing? Use and avoidance of continuity corrections in meta-analysis of sparse data*, Statistics in Medicine, doi:10.1002/sim.1761.

113. **Deng**, H., *PyMeta, Python module for meta-analysis*, www.pymeta.com/.