

Losartan for COVID-19: real-time meta analysis of 5 studies

@CovidAnalysis, July 2025, Version 2

<https://c19early.org/lsmeta.html>

Abstract

Meta analysis using the most serious outcome reported shows 15% [-42-127%] higher risk, without reaching statistical significance. Currently all studies are RCTs.

Currently there is limited data, with only 665 patients and only 14 control events for the most serious outcome in trials to date.

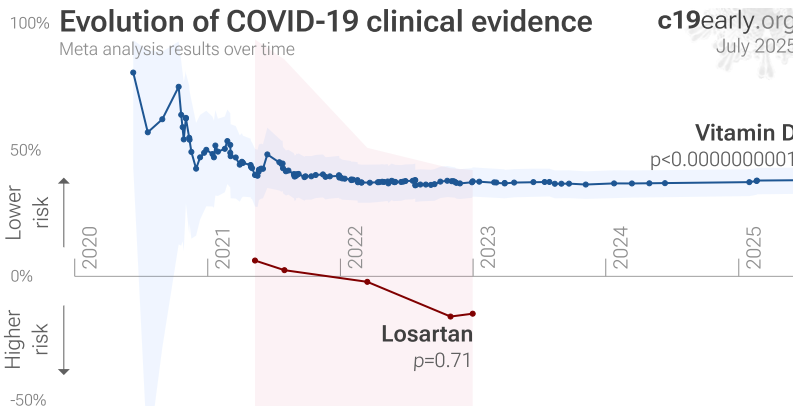
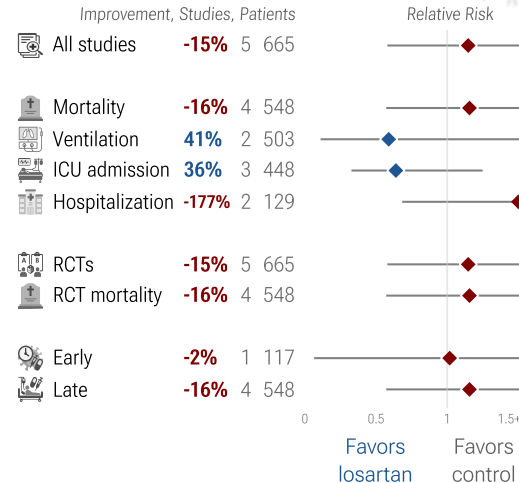
All data and sources to reproduce this analysis are in the appendix.

Serious Outcome Risk



Losartan for COVID-19

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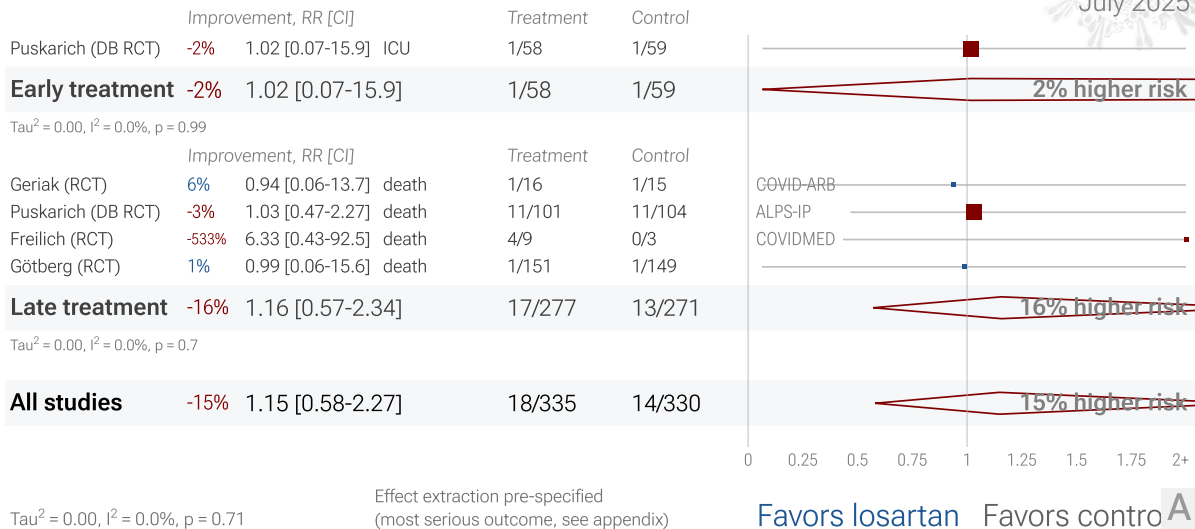


LOSARTAN FOR COVID-19 — HIGHLIGHTS

Meta analysis of studies to date shows no significant improvements with losartan.

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.

5 losartan COVID-19 studies



Timeline of COVID-19 losartan studies (pooled effects)

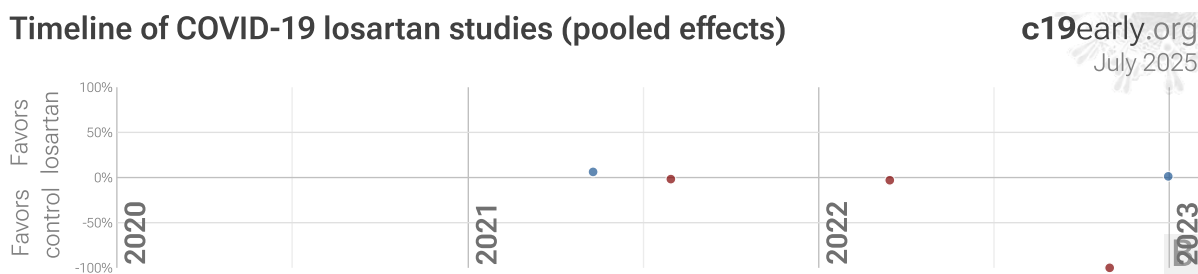


Figure 1. A. Random effects meta-analysis. This plot shows pooled effects, see the specific outcome analyses for individual outcomes. Analysis validating pooled outcomes for COVID-19 can be found [below](#). Effect extraction is pre-specified, using the most serious outcome reported. For details see the appendix. **B. Timeline of results in losartan 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 injury²⁻¹⁴ and cognitive deficits^{5,10}, cardiovascular complications¹⁵⁻¹⁹, organ failure, and death. Even mild untreated infections may result in persistent cognitive deficits²⁰—the spike protein binds to fibrin leading to fibrinolysis-resistant blood clots, thromboinflammation, and neuropathology. Minimizing replication as early as possible is recommended.

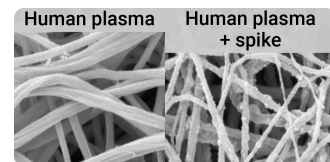


Figure 2. SARS-CoV-2 spike protein fibrin binding leads to thromboinflammation and neuropathology, from ¹.

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,21-28}, providing many therapeutic targets for which many existing compounds have known activity. Scientists have predicted that over 9,000 compounds may reduce COVID-19 risk²⁹, either by directly minimizing infection or replication, by supporting immune system function, or by minimizing secondary complications.

Analysis

We analyze all significant controlled studies of losartan 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, 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.

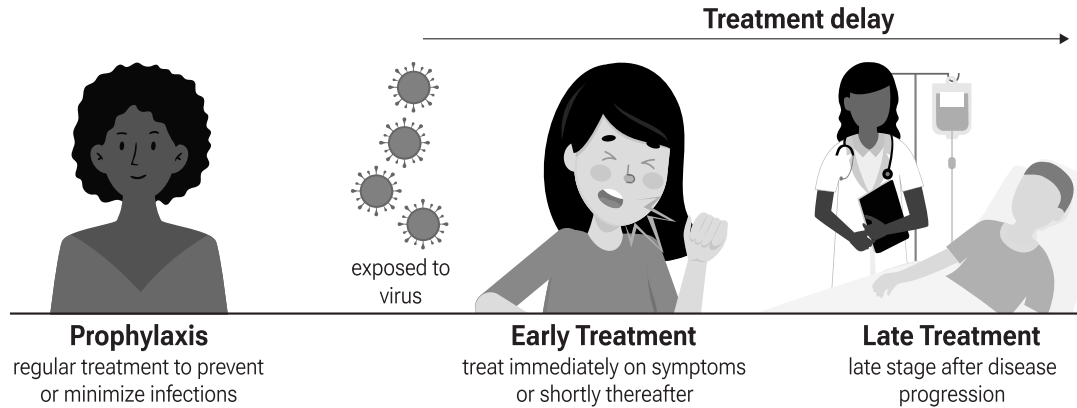


Figure 3. Treatment stages.

Results

Table 1 summarizes the results for all stages combined, for Randomized Controlled Trials, 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, and 11 show forest plots for random effects meta-analysis of all studies with pooled effects, mortality results, ventilation, ICU admission, hospitalization, progression, and recovery.

	Relative Risk	Studies	Patients
All studies	1.15 [0.58-2.27]	5	665
RCTs	1.15 [0.58-2.27]	5	665
Mortality	1.16 [0.57-2.34]	4	548
Ventilation	0.59 [0.11-3.15]	2	503
ICU admission	0.64 [0.33-1.25]	3	448
Hospitalization	2.77 [0.68-11.22]	2	129
RCT mortality	1.16 [0.57-2.34]	4	548

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

	Early treatment	Late treatment
All studies	1.02 [0.07-15.88]	1.16 [0.57-2.34]
RCTs	1.02 [0.07-15.88]	1.16 [0.57-2.34]
Mortality		1.16 [0.57-2.34]
Ventilation		0.59 [0.11-3.15]
ICU admission	1.02 [0.07-15.88]	0.62 [0.31-1.24]
Hospitalization	3.05 [0.33-28.49]	2.60 [0.43-15.66]
RCT mortality		1.16 [0.57-2.34]

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

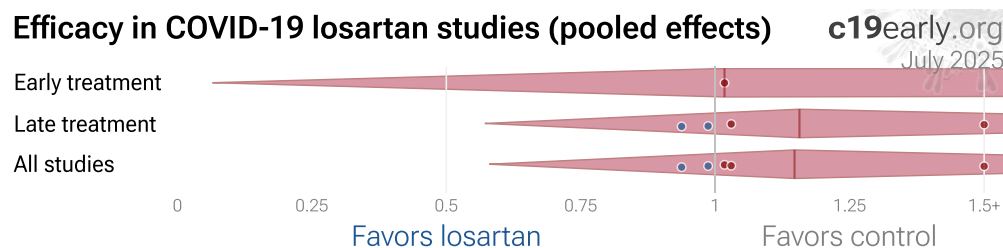


Figure 4. Scatter plot showing the most serious outcome in all studies, and for studies within each stage. Diamonds shows the results of random effects meta-analysis.

5 losartan COVID-19 studies

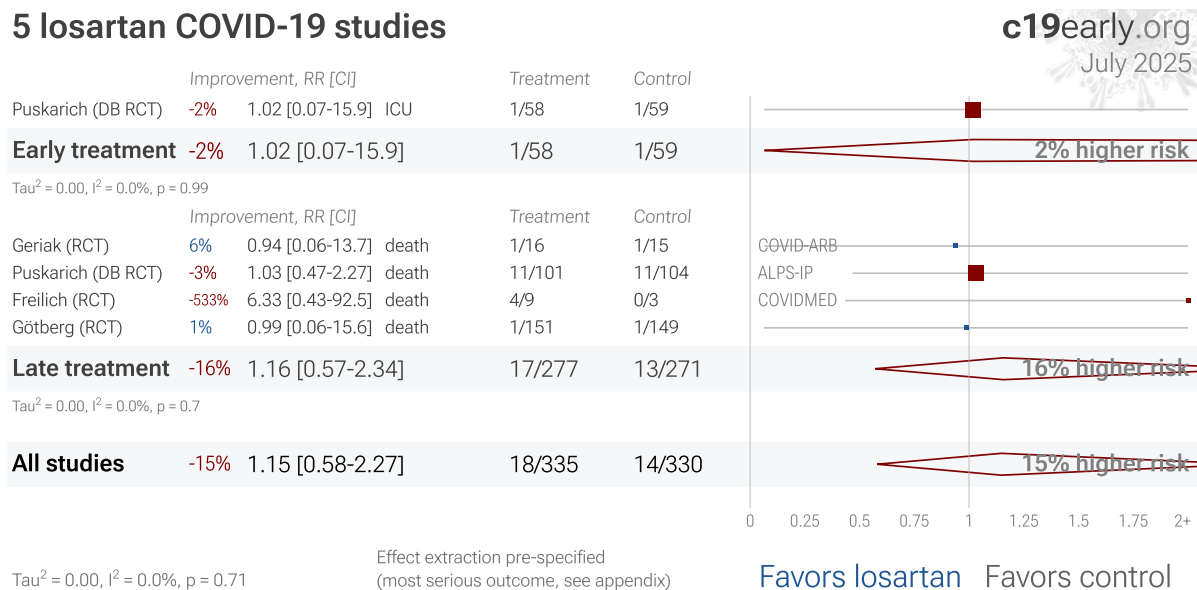


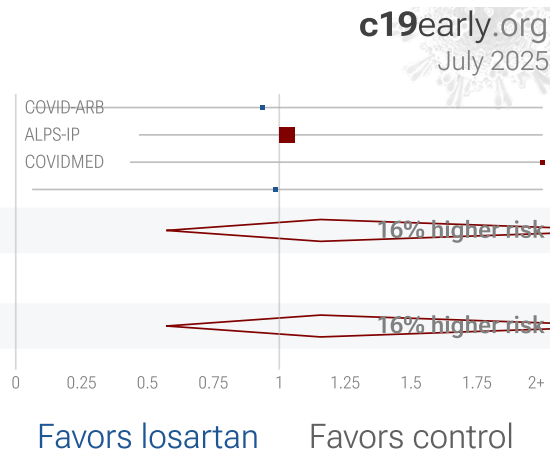
Figure 5. Random effects meta-analysis for all studies. This plot shows pooled effects, see the specific outcome analyses for individual outcomes. Analysis validating pooled outcomes for COVID-19 can be found [below](#). Effect extraction is pre-specified, using the most serious outcome reported. For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

4 losartan COVID-19 mortality results

	Improvement, RR [CI]	Treatment	Control
Geriak (RCT)	6% 0.94 [0.06-13.7]	1/16	1/15
Puskarich (DB RCT)	-3% 1.03 [0.47-2.27]	11/101	11/104
Freilich (RCT)	-53% 6.33 [0.43-92.5]	4/9	0/3
Götberg (RCT)	1% 0.99 [0.06-15.6]	1/151	1/149
Late treatment	-16% 1.16 [0.57-2.34]	17/277	13/271

Tau² = 0.00, I² = 0.0%, p = 0.7

All studies	-16% 1.16 [0.57-2.34]	17/277	13/271
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Tau² = 0.00, I² = 0.0%, p = 0.7

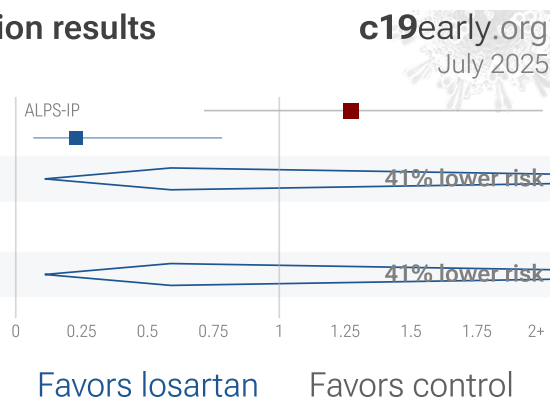
Figure 6. Random effects meta-analysis for mortality results.

2 losartan COVID-19 mechanical ventilation results

	Improvement, RR [CI]	Treatment	Control
Puskarich (DB RCT)	-27% 1.27 [0.71-2.27]	21/100	17/103
Götberg (RCT)	77% 0.23 [0.07-0.78]	3/151	13/149
Late treatment	41% 0.59 [0.11-3.15]	24/251	30/252

Tau² = 1.24, I² = 83.7%, p = 0.55

All studies	41% 0.59 [0.11-3.15]	24/251	30/252
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Tau² = 1.24, I² = 83.7%, p = 0.55

Figure 7. Random effects meta-analysis for ventilation.

3 losartan COVID-19 ICU results

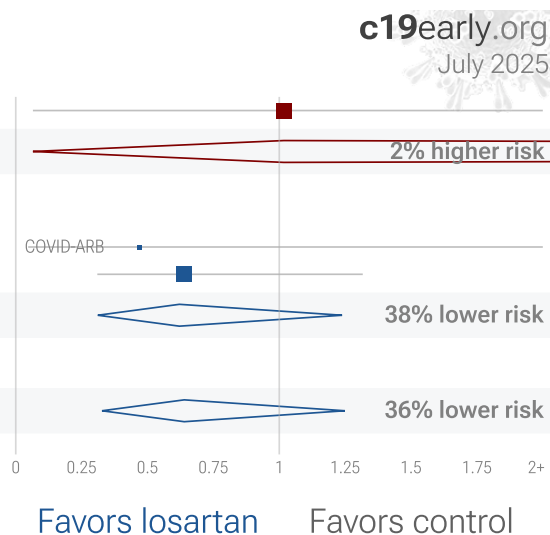
	Improvement, RR [CI]	Treatment	Control
Puskarich (DB RCT)	-2% 1.02 [0.07-15.9]	1/58	1/59
Early treatment	-2% 1.02 [0.07-15.9]	1/58	1/59

Tau² = 0.00, I² = 0.0%, p = 0.99

	Improvement, RR [CI]	Treatment	Control
Geriak (RCT)	53% 0.47 [0.05-4.65]	1/16	2/15
Götberg (RCT)	36% 0.64 [0.31-1.32]	11/151	17/149
Late treatment	38% 0.62 [0.31-1.24]	12/167	19/164

Tau² = 0.00, I² = 0.0%, p = 0.18

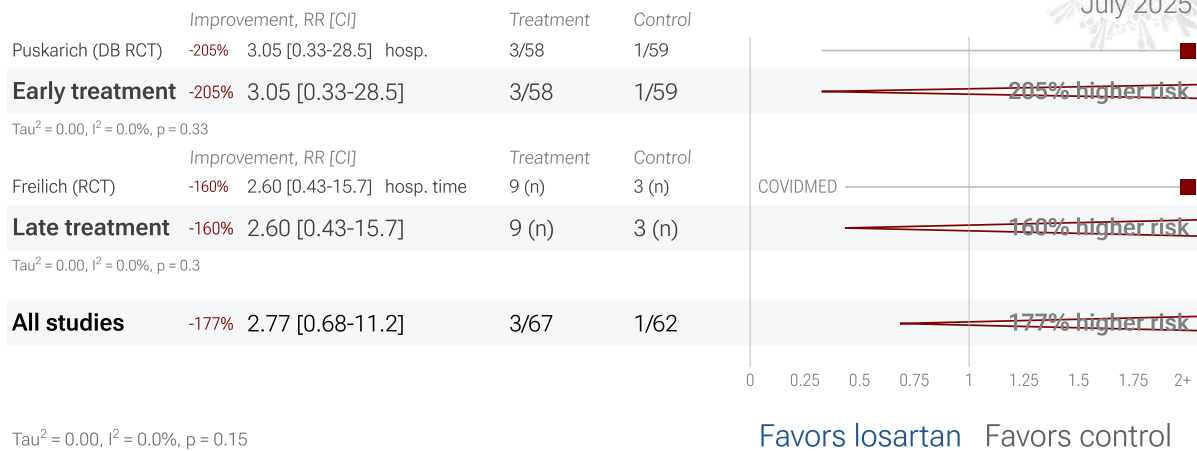
All studies	36% 0.64 [0.33-1.25]	13/225	20/223
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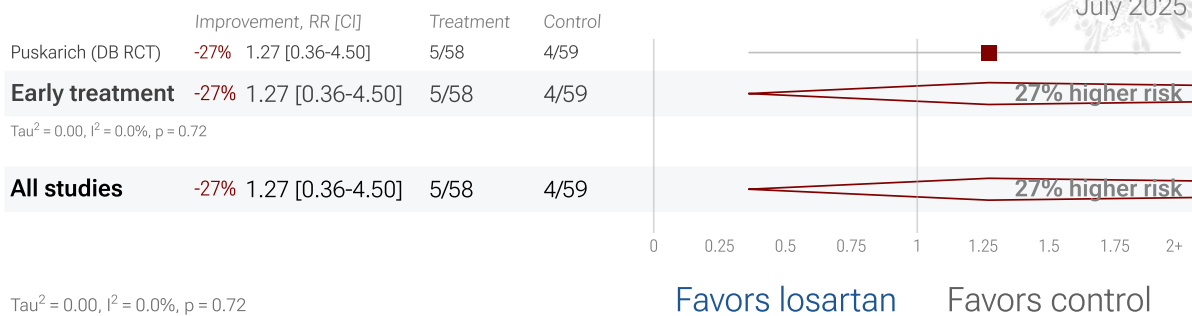
Tau² = 0.00, I² = 0.0%, p = 0.19

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

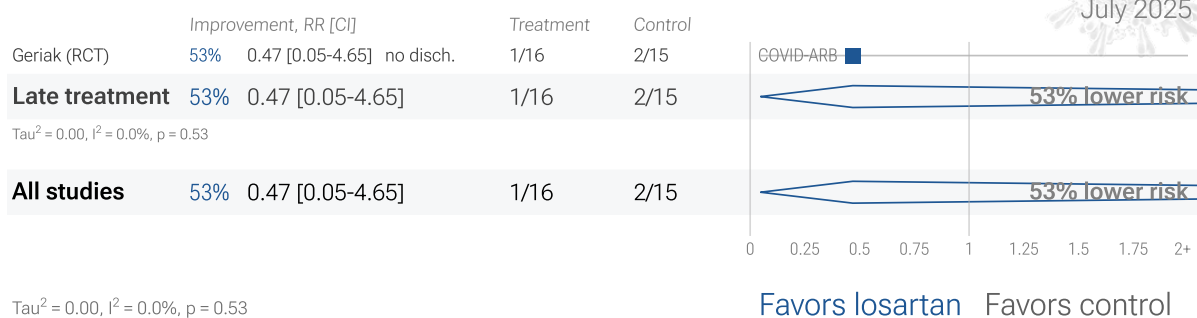
2 losartan COVID-19 hospitalization results



1 losartan COVID-19 progression result



1 losartan COVID-19 recovery result



Randomized Controlled Trials (RCTs)

Currently all studies are RCTs.

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^{30,31}. 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 ³²
<24 hours	-33 hours symptoms ³³
24-48 hours	-13 hours symptoms ³³
Inpatients	-2.5 hours to improvement ³⁴

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

Figure 12 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.

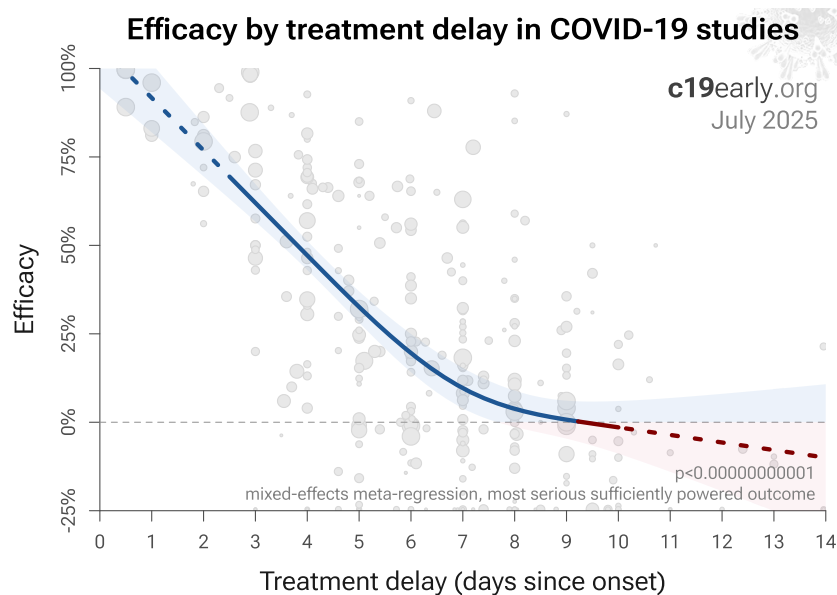


Figure 12. Early treatment is more effective. Meta-regression showing efficacy as a function of treatment delay in COVID-19 studies from 172 treatments.

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 variants³⁶, for example the Gamma variant shows significantly different characteristics³⁷⁻⁴⁰. 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^{41,42}.

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 synergistic⁴⁵⁻⁶¹, 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 13 shows that lower hospitalization is very strongly associated with lower mortality ($p < 0.000000000001$). Similarly, Figure 14 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 15 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 $p = 0.0000000033$.

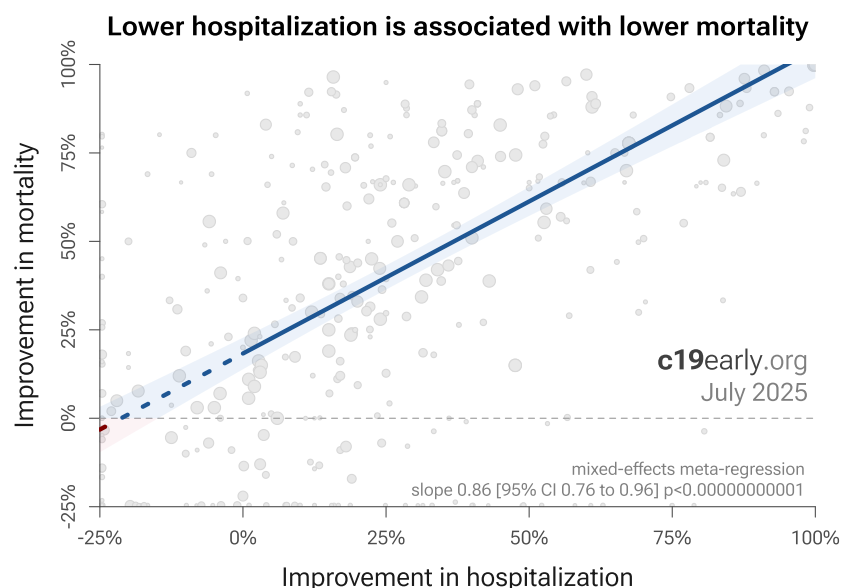


Figure 13. Lower hospitalization is associated with lower mortality, supporting pooled outcome analysis.

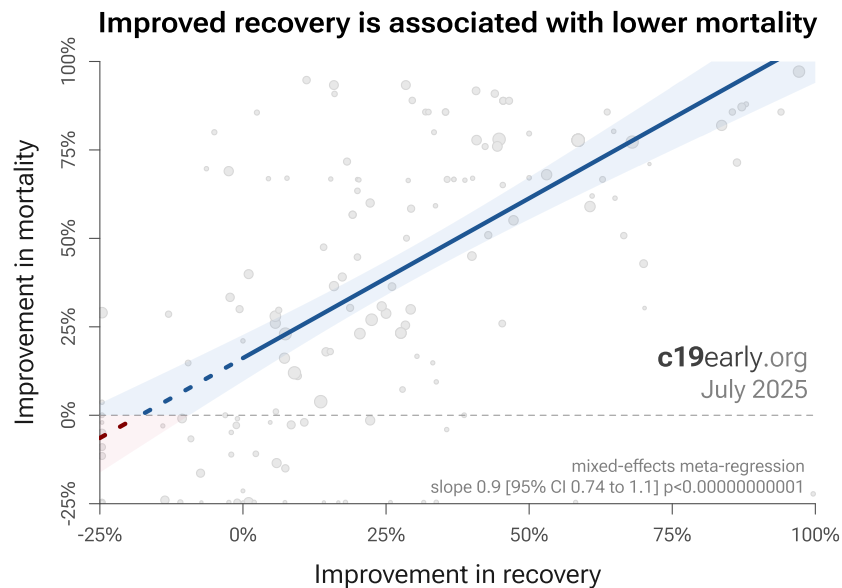


Figure 14. Improved recovery is associated with lower mortality, supporting pooled outcome analysis.

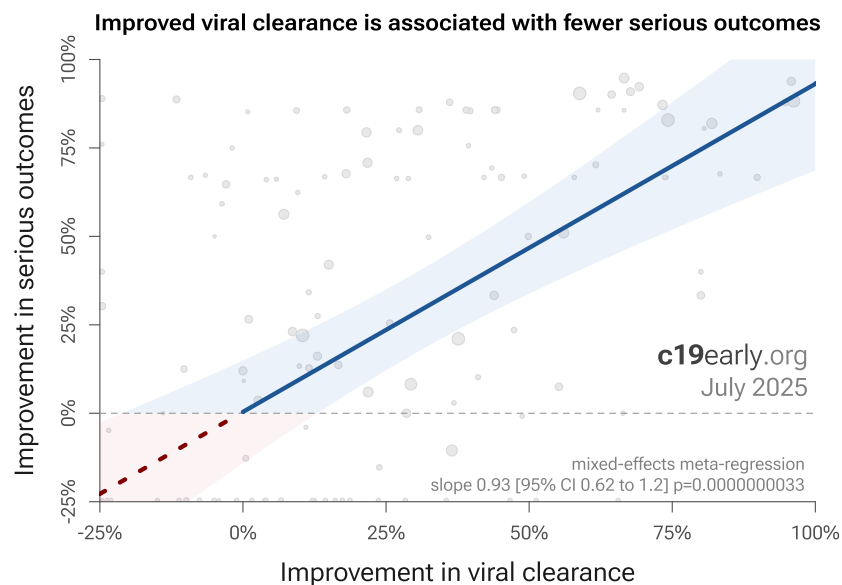


Figure 13. Improved viral clearance is associated with fewer serious outcomes, supporting pooled outcome analysis.

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 $\geq 10\%$ 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 16 shows when treatments were found effective during the pandemic. Pooled outcomes often resulted in earlier detection of efficacy.

Time when COVID-19 studies showed efficacy

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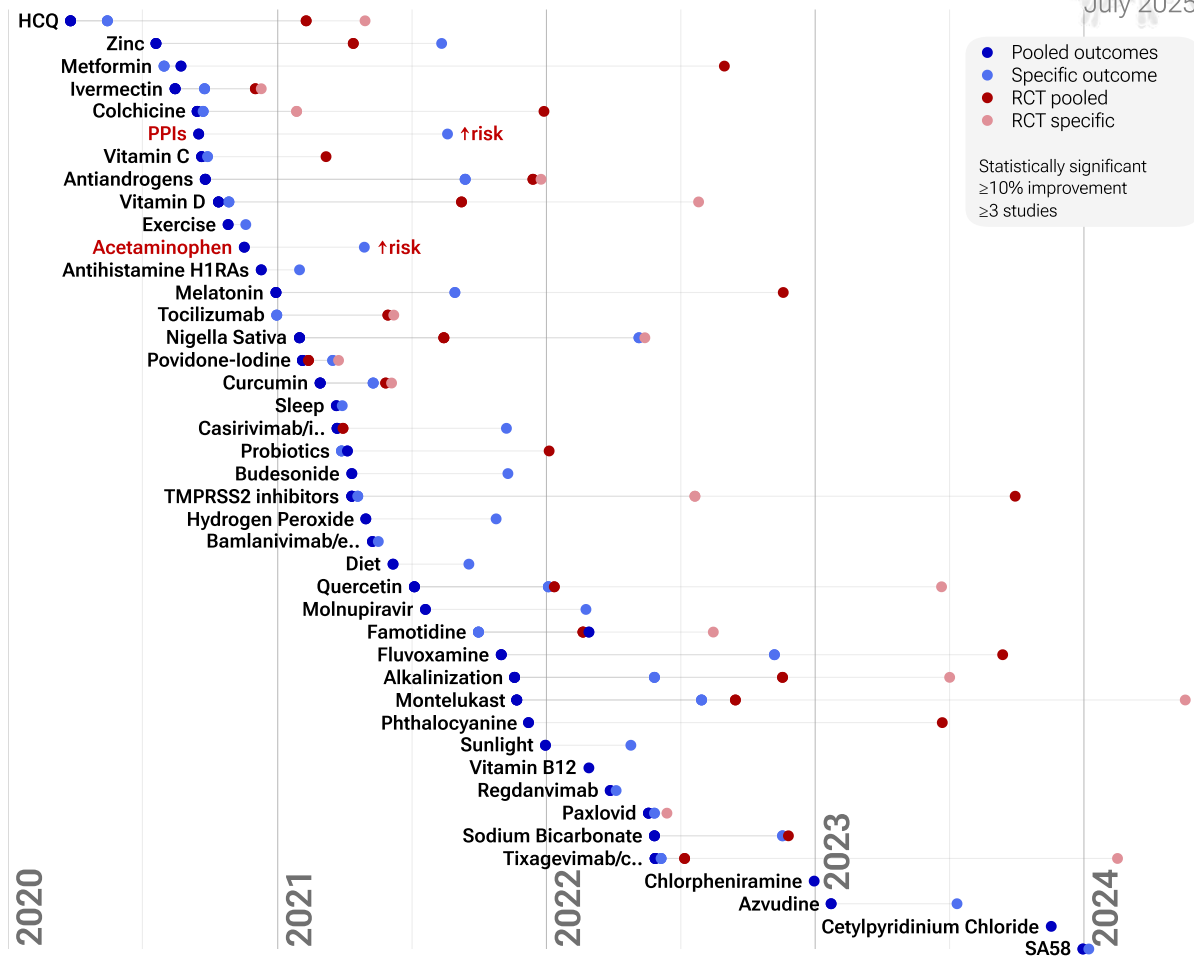


Figure 16. The time when studies showed that treatments were effective, defined as statistically significant improvement of $\geq 10\%$ from ≥ 3 studies. Pooled results typically show efficacy earlier than specific outcome results. Results from all studies often shows efficacy much earlier than when 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 results⁶³⁻⁶⁶. For losartan, there is currently not enough data to evaluate publication bias with high confidence.

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. Losartan for COVID-19 lacks this because it is off-patent, has multiple manufacturers, and is very low cost. In contrast, most COVID-19 losartan 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 losartan 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 alone⁴⁵⁻⁶¹. 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.

Perspective

Results compared with other treatments

SARS-CoV-2 infection and replication involves a complex interplay of 100+ host and viral proteins and other factors²¹⁻²⁸, providing many therapeutic targets. Over 9,000 compounds have been predicted to reduce COVID-19 risk²⁹, either by directly minimizing infection or replication, by supporting immune system function, or by minimizing secondary complications. Figure 17 shows an overview of the results for losartan in the context of multiple COVID-19 treatments, and Figure 18 shows a plot of efficacy vs. cost for COVID-19 treatments.

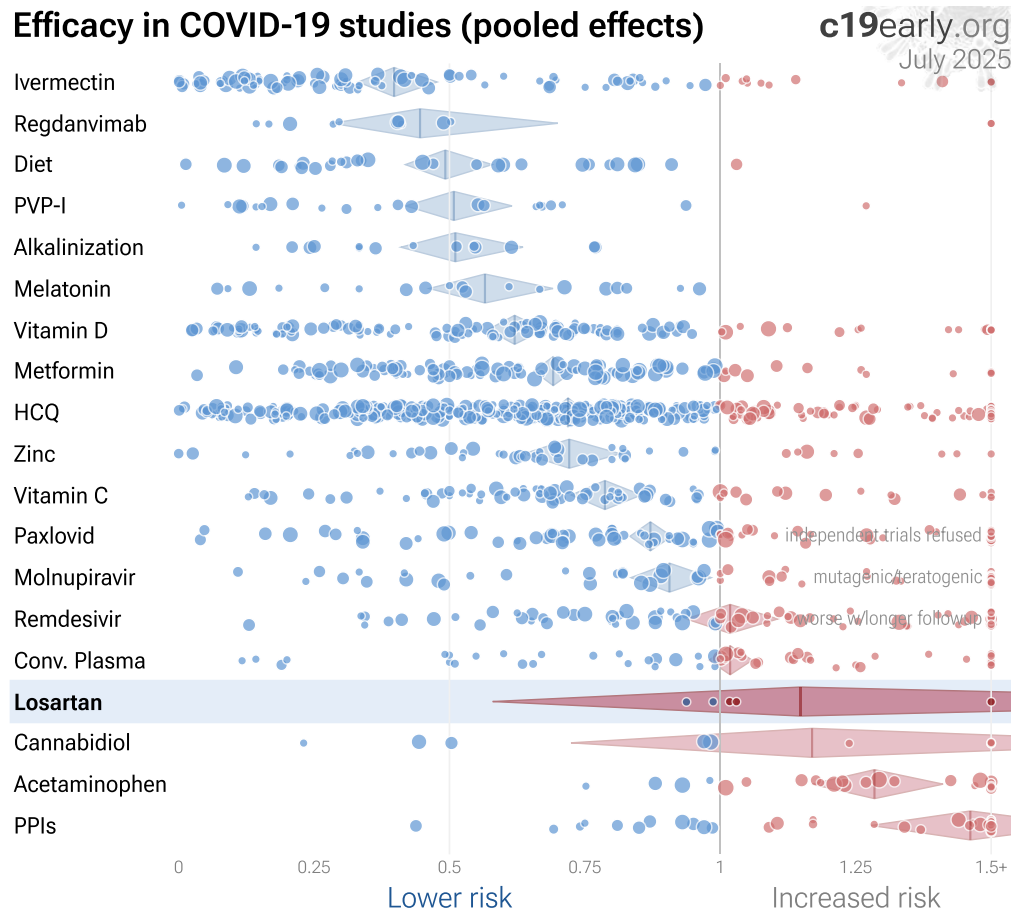


Figure 17. Scatter plot showing results within the context of multiple COVID-19 treatments. Diamonds shows the results of random effects meta-analysis. 0.6% of 9,000+ proposed treatments show efficacy⁶⁷.

Efficacy vs. cost for COVID-19 treatments

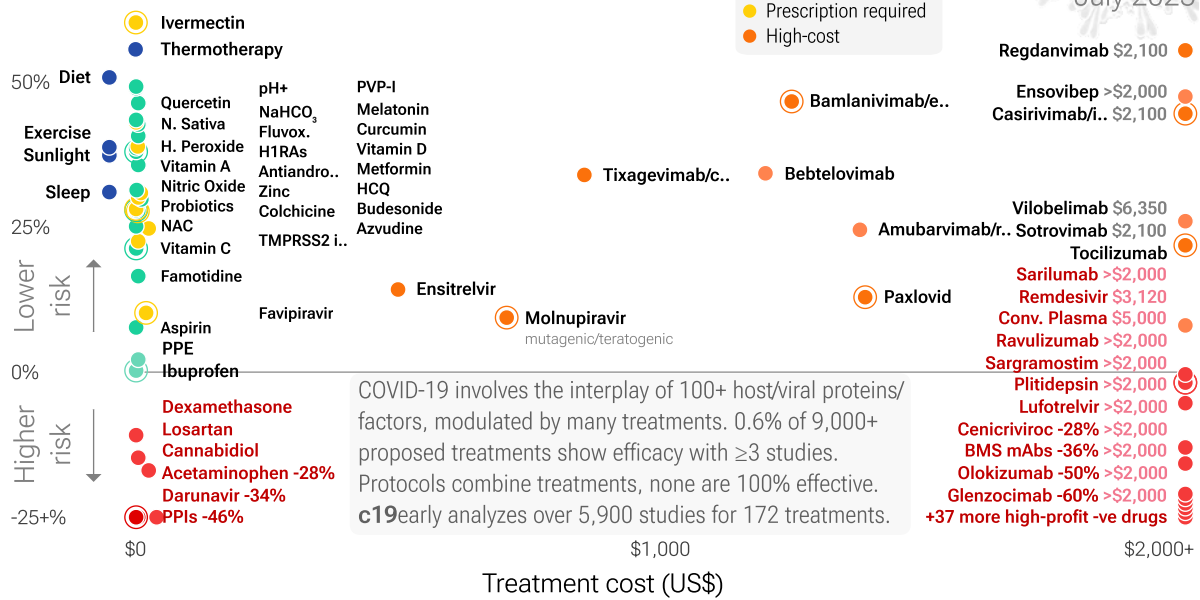


Figure 18. Efficacy vs. cost for COVID-19 treatments.

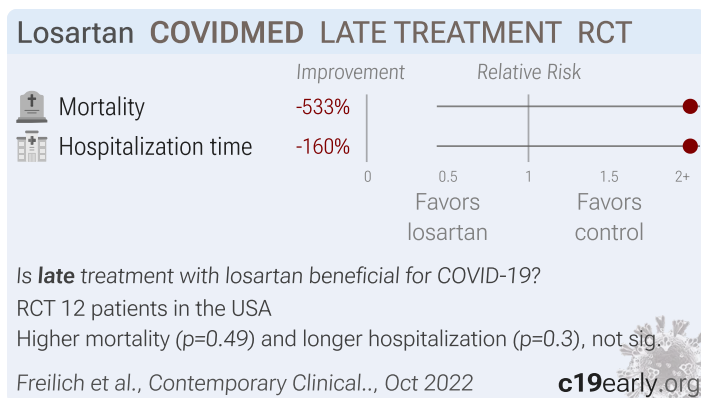
Conclusion

Meta analysis using the most serious outcome reported shows 15% [-42-127%] higher risk, without reaching statistical significance. Currently all studies are RCTs.

Currently there is limited data, with only 665 patients and only 14 control events for the most serious outcome in trials to date.

Study Notes

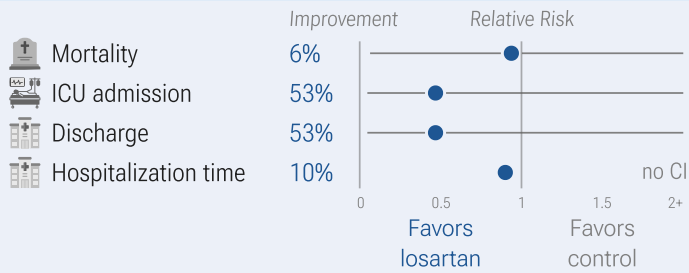
Freilich



RCT 15 hospitalized COVID-19 patients showing no significant differences with losartan treatment. The study was terminated early due to low enrollment.

Geriak

Losartan COVID-ARB LATE TREATMENT RCT



Is **late** treatment with losartan beneficial for COVID-19?

RCT 31 patients in the USA (March - July 2020)

Lower ICU admission ($p=0.6$) and higher discharge ($p=0.6$), not sig.

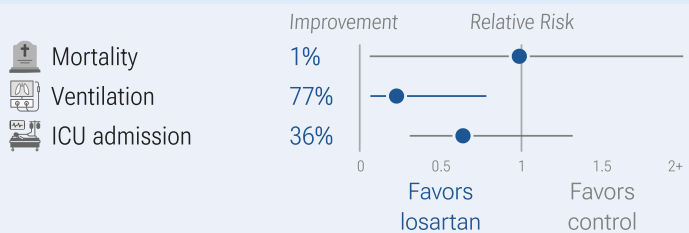
Geriak et al., Infectious Diseases and..., May 2021

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RCT 31 hospitalized COVID-19 patients with mild hypoxemia showing no significant difference in mechanical ventilation, ICU admission, or mortality with addition of losartan to standard care.

Götberg

Losartan Götberg et al. LATE TREATMENT RCT



Is **late** treatment with losartan beneficial for COVID-19?

RCT 300 patients in Sweden

Lower ventilation with losartan ($p=0.01$)

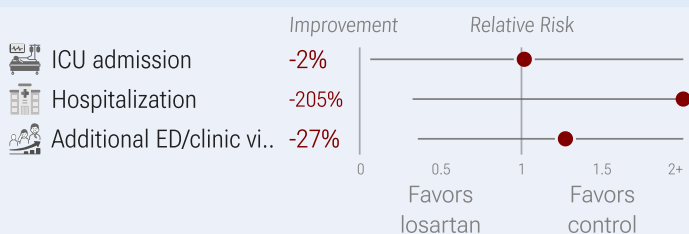
Götberg et al., SSRN Electronic J., Dec 2022

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RCT 302 hospitalized COVID-19 patients showing lower mechanical ventilation but no significant difference in ICU admission or mortality with losartan treatment.

Puskarich

Losartan Puskarich et al. EARLY TREATMENT DB RCT



Is **early** treatment with losartan beneficial for COVID-19?

Double-blind RCT 117 patients in the USA (April - November 2020)

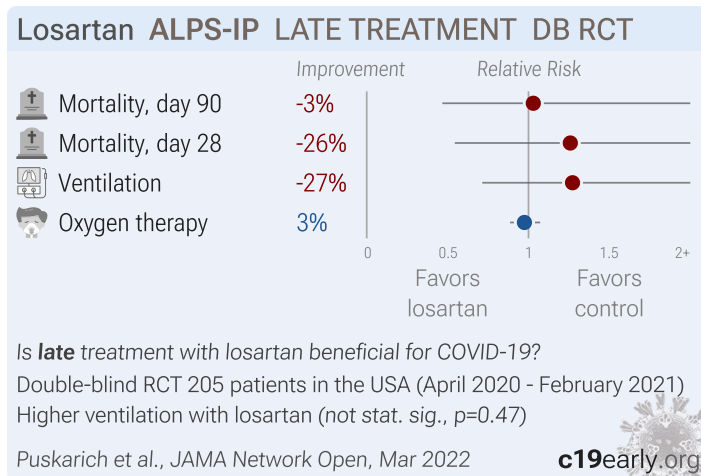
Higher hospitalization with losartan (not stat. sig., $p=0.36$)

Puskarich et al., eClinicalMedicine, Jul 2021

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RCT 117 symptomatic outpatients showing no significant difference in hospitalization, functional status, dyspnea, or viral load with losartan treatment. The trial was terminated early due to low event rates. Losartan 25mg twice daily for 10 days.

Puskarich



RCT 205 hospitalized COVID-19 patients showing no significant difference in lung injury (PaO₂:FiO₂ ratio) at day 7 with losartan treatment, and no difference in clinical outcomes including mortality. Losartan was associated with more adverse events including acute kidney injury and need for vasopressors. Results suggest losartan is not beneficial and may cause harm in this setting.

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 losartan 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 losartan 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.

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

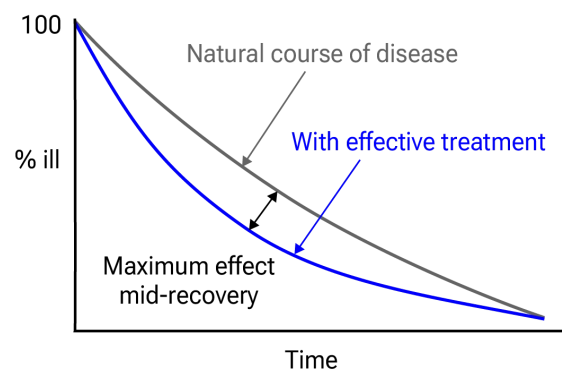


Figure 19. Mid-recovery results can more accurately reflect efficacy when almost all patients recover. Mateja et al. confirm that intermediate viral load results more accurately reflect hospitalization/death.

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 reduction⁶⁸. If only individual symptom data is available, the most serious symptom has priority, for example difficulty breathing or low SpO₂ 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 1⁷². 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*⁷³ 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. *Grobidi* 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^{30,31}.

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

<i>Puskarich</i> , 7/31/2021, Double Blind Randomized Controlled Trial, placebo-controlled, USA, peer-reviewed, 19 authors, study period April 2020 - November 2020, trial NCT04311177 (history).	risk of ICU admission, 1.7% higher, RR 1.02, <i>p</i> = 1.00, treatment 1 of 58 (1.7%), control 1 of 59 (1.7%).
	risk of hospitalization, 205.2% higher, RR 3.05, <i>p</i> = 0.36, treatment 3 of 58 (5.2%), control 1 of 59 (1.7%).
	additional ED/clinic visits, 27.2% higher, RR 1.27, <i>p</i> = 0.74, treatment 5 of 58 (8.6%), control 4 of 59 (6.8%).

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.

Freilich, 10/31/2022, Randomized Controlled Trial, placebo-controlled, USA, peer-reviewed, mean age 69.8, 4 authors, trial NCT04340557 (history) (COVIDMED).	risk of death, 533.3% higher, RR 6.33, $p = 0.49$, treatment 4 of 9 (44.4%), control 0 of 3 (0.0%), continuity correction due to zero event (with reciprocal of the contrasting arm).
	hospitalization time, 160.3% higher, relative time 2.60, $p = 0.30$, treatment 9, control 3.
Geriak, 5/11/2021, Randomized Controlled Trial, USA, peer-reviewed, median age 53.0, 8 authors, study period 30 March, 2020 - 4 July, 2020, trial NCT04340557 (history) (COVID-ARB).	risk of death, 6.2% lower, RR 0.94, $p = 1.00$, treatment 1 of 16 (6.2%), control 1 of 15 (6.7%), NNT 240.
	risk of ICU admission, 53.1% lower, RR 0.47, $p = 0.60$, treatment 1 of 16 (6.2%), control 2 of 15 (13.3%), NNT 14.
	risk of no hospital discharge, 53.1% lower, RR 0.47, $p = 0.60$, treatment 1 of 16 (6.2%), control 2 of 15 (13.3%), NNT 14.
Götberg, 12/31/2022, Randomized Controlled Trial, Sweden, peer-reviewed, 11 authors.	risk of death, 1.3% lower, RR 0.99, $p = 1.00$, treatment 1 of 151 (0.7%), control 1 of 149 (0.7%), NNT 11250.
	risk of mechanical ventilation, 77.2% lower, RR 0.23, $p = 0.01$, treatment 3 of 151 (2.0%), control 13 of 149 (8.7%), NNT 15.
	risk of ICU admission, 36.2% lower, RR 0.64, $p = 0.24$, treatment 11 of 151 (7.3%), control 17 of 149 (11.4%), NNT 24.
Puskarich (B), 3/16/2022, Double Blind Randomized Controlled Trial, placebo-controlled, USA, peer-reviewed, 36 authors, study period April 2020 - February 2021, trial NCT04312009 (history) (ALPS-IP).	risk of death, 3.0% higher, RR 1.03, $p = 1.00$, treatment 11 of 101 (10.9%), control 11 of 104 (10.6%), day 90.
	risk of death, 25.9% higher, RR 1.26, $p = 0.64$, treatment 11 of 101 (10.9%), control 9 of 104 (8.7%), day 28.
	risk of mechanical ventilation, 27.2% higher, RR 1.27, $p = 0.47$, treatment 21 of 100 (21.0%), control 17 of 103 (16.5%).
	risk of oxygen therapy, 2.5% lower, RR 0.97, $p = 0.66$, treatment 89 of 101 (88.1%), control 94 of 104 (90.4%), NNT 44.

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.

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