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Cite this as: *BMJ* 2020;370:m3379
http://dx.doi.org/10.1136/bmj.m3379
Published: 4 September 2020

RAPID RECOMMENDATIONS

A living WHO guideline on drugs for covid-19

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ABSTRACT

CLINICAL QUESTION

What is the role of drug interventions in the treatment of patients with covid-19?

NEW RECOMMENDATION

The latest version of this WHO living guidance focuses on remdesivir, following the 15 October 2020 preprint publication of results from the WHO SOLIDARITY trial. It contains a weak or conditional recommendation against the use of remdesivir in hospitalised patients with covid-19

RECOMMENDATIONS

The first version on this living guidance focused on corticosteroids. The strong recommendation for systemic corticosteroids in patients with severe and critical covid-19, and a weak or conditional recommendation against systemic corticosteroids in patients with non-severe covid-19 are unchanged.

HOW THIS GUIDELINE WAS CREATED

WHO has partnered with the non-profit Magic Evidence Ecosystem Foundation (MAGIC) for methodologic support, to develop and disseminate living guidance for covid-19 drug treatments, based on a living systematic review and network analysis. An international standing Guideline Development Group (GDG) of content experts, clinicians, patients, and methodologists produced recommendations following standards for trustworthy guideline development using the GRADE approach. No competing interests were identified for any panel member.

UNDERSTANDING THE NEW RECOMMENDATION

When moving from evidence to the conditional recommendation against the use of remdesivir in patients with covid-19, the panel emphasised the evidence suggesting no important effect on mortality, need for mechanical ventilation, time to clinical improvement, and other patient-important outcomes. Considering the low or very low certainty evidence for all outcomes, the panel interpreted the evidence as not proving that remdesivir is ineffective; rather, there is no evidence based on currently available data that it does improve patient-important outcomes. The panel placed low value on small and uncertain benefits in the presence of the remaining possibility of important harms. In addition, the panel considered contextual factors such as resources, feasibility, acceptability, and equity for countries and health care systems.

UPDATES

This is a living guideline. It replaces an earlier version published on 4 September 2020 and the *BMJ* Rapid Recommendations on remdesivir published on 2 July 2020, and the previous version can be found as a data supplement. Future updates are planned to cover hydroxychloroquine and lopinavir-rotinavir. New recommendations will be published as updates to this guideline.

READERS NOTE

This version is update 1 of the living guideline (*BMJ* 2020;370:m3379). When citing this article, please consider adding the update number and date of access for clarity.

This living guideline responds to emerging evidence from randomised controlled trials (RCTs) on existing and new drug treatments for covid-19. More than 2800 trials on covid-19 interventions have been registered or are ongoing (see section on emerging evidence[1]). Among these are large international platform trials (such as RECOVERY, WHO SOLIDARITY, and DISCOVERY) that recruit large numbers of patients in many countries, with a pragmatic and adaptive design.[2 3] These platform trials are currently investigating and reporting on drugs such as remdesivir, corticosteroids, hydroxychloroquine, and lopinavir-ritonavir, with other interventions under way (such as convalescent plasma, immunomodulatory therapies). This rapidly evolving evidence landscape requires trustworthy interpretation and expeditious clinical practice guidelines to inform clinicians, patients, governments, ministries, and health administrators.

A living network meta-analysis associated with this guideline will incorporate new trial data as the evidence base increases and allow for analysis of comparative effectiveness of multiple covid-19 treatments.[4] This network meta-analysis and other related publications are included in box 1. We will also use additional relevant evidence on long term safety, prognosis, and patient values and preferences related to covid-19 treatments to inform the living guidance.

Box 1: Linked resources in this *BMJ* Rapid Recommendations cluster

- Rochwerg B, Agoritsas T, Lamontagne F, et al. A living WHO guideline on drugs for covid-19 [Update 1]. *BMJ* 2020;370:m3379
- World Health Organization. *Therapeutics and COVID-19. Living guideline*. 20 Nov 2020. https://www.who.int/publications/i/item/therapeutics-and-covid-19-living-guideline. Also *Corticosteroids for COVID-19. Living guidance*. 2 Sep 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-Corticosteroids-2020.1
- Siemieniuk RAC, Bartoszko JJ, Ge L, et al. Drug treatments for covid-19: living systematic review and network meta-analysis [Update 1]. *BMJ* 2020;370:m2980, doi:10.1136/bmj.m2980
  - Preprint data for update 2 are available in the appendix of the WHO living guideline
- Izcovich A, Siemieniuk RAC, Bartoszko JJ, et al. Adverse effects of remdesivir, hydroxychloroquine, and lopinavir/ritonavir when used for COVID-19: systematic review and meta-analysis of randomized trials. Preprint available at: https://www.medrxiv.org/content/10.1101/2020.11.16.20232876v1
- MAGICapp (https://app.magicapp.org/#/guideline/nBkO1E)
  - Expanded version of the methods, processes, and results with multilayered recommendations, evidence summaries, and decision aids for use on all devices

What triggered this version of the guideline?

This second version of the WHO living guideline addresses the use of remdesivir in patients with covid-19. It follows the preprint publication of the WHO SOLIDARITY trial on 15 October 2020, reporting results on treatment with remdesivir, hydroxychloroquine, and lopinavir-ritonavir in hospitalised patients with covid-19.[2] The role of these drugs in clinical practice has remained uncertain, with limited prior trial evidence. The WHO SOLIDARITY trial adds 11 266 randomised patients (2570 to remdesivir, 954 to hydroxychloroquine, and 1411 to lopinavir-ritonavir, 6331 to usual care) and holds the potential to change practice.[2]

The WHO Guideline Development Group (GDG) started with developing trustworthy recommendations on remdesivir and plan recommendations on hydroxychloroquine and lopinavir-ritonavir to follow shortly. Remdesivir is a novel monophosphoramidate adenosine analogue prodrug which is metabolised to an active tri-phosphate form that inhibits viral RNA synthesis. Remdesivir has in vitro and in vivo antiviral activity against several viruses, including SARS-CoV-2. Remdesivir is widely used in many countries, with several guidelines recommending its use in patients with severe or critical covid-19.[5 6]

How to use this guideline?

This is a living guideline, so the recommendations included here will be updated, and new recommendations will be added on other therapies for covid-19. The infographic provides a summary of the recommendations and includes links to the MAGICapp for more details on the evidence and rationale for the recommendation, as well as patient decision aids. Box 2 outlines key methodological aspects of the guideline process.

Box 2: How this living guideline was created (see MAGICapp for full details https://app.magicapp.org/#/guideline/nBkO1E)

This guideline was developed by WHO and the MAGIC Evidence Ecosystem Foundation (MAGIC), with support from *The BMJ*. It is driven by an urgent need for trustworthy and living guidance to rapidly inform policy and practice worldwide during the covid-19 pandemic. WHO has partnered with MAGIC for their methodologic support in the development and dissemination of living guidance for covid-19 drug treatments, in the form of *BMJ* Rapid Recommendations, to provide patients, clinicians, and policy makers with up to date, evidence based, and user friendly guidelines.

Standards, methods, and processes for living and trustworthy guidance

The panel produced the recommendations following standards for trustworthy guideline development using the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach, in compliance with the *WHO Handbook for Guideline Development 2nd Edition*,[7] the Institute of Medicine, and the Guideline International Network (G-I-N).[8] Details are provided in the WHO guideline (link to website) and MAGICapp (https://app.magicapp.org/#/guideline/nBkO1E).

Selection and support of the panel

For the remdesivir recommendation, WHO convened an international guideline development panel with 28 individuals, of whom 24 were content experts (clinicians, methodologists, scientists) and four were patients who survived covid-19. The methods chair (methodological expertise) and a clinical chair (content expertise) guided the panel discussions. Panel members were invited by WHO, after consultation with the methods chair and MAGIC, with the aim of achieving gender, geography, expertise, and patient representation balance in the panel. No relevant conflict of interest was identified for any panel member.

As recommended by the WHO handbook, the panel aimed to create a recommendation based on consensus but elected, at the beginning of the first panel meeting, to call a vote if a consensus could not be reached. Before discussions started, the panel determined that a simple majority would provide the direction of the recommendation and that 80% would be required to make a strong recommendation.

Guideline perspective, outcomes, and values and preferences

The target audience for this guidance consists primarily of clinicians, but secondarily of patients and healthcare decision makers. The panel considered an individual patient perspective but also took account of contextual factors (such as resources, feasibility, acceptability, equity) to accommodate global re-use and adaptation for countries and healthcare systems.

During a pandemic, access to healthcare may vary over time and between different countries. The panel defined covid-19 by clinical severity, and mutually exclusive definitions are provided in box 3.

There were insufficient published data to provide the GDG with an informative systematic review of studies describing patients' experiences or values and preferences on treatment decisions for covid-19 drug treatments. The GDG therefore relied on their own judgments of what well informed patients would value after carefully balancing the benefits, harms, and burdens of treatment and their subsequent treatment preferences. The GDG included four patient representatives who had lived experience with covid-19.

The GDG agreed that the following values and preferences would be representative of those of typical well informed patients:

- Mortality would be the outcome most important to patients, followed by need and duration of mechanical ventilation, time to clinical improvement, and serious intervention-related adverse events
- Most patients would be reluctant to use a medication for which the evidence left high uncertainty regarding effects on the outcomes listed above. This was particularly so when evidence suggested treatment effects, if they exist, are small and the possibility of important harm remains.

- In an alternative situation with larger benefits and less uncertainty regarding both benefits and harms, more patients would be inclined to choose the intervention.

The GDG acknowledged, however, that values and preferences are likely to vary. There will be patients inclined to use a treatment in which evidence has not excluded important benefit, particularly when the underlying condition is potentially fatal. On the other hand, there will be those who have a high threshold of likely benefit before they will choose the intervention.

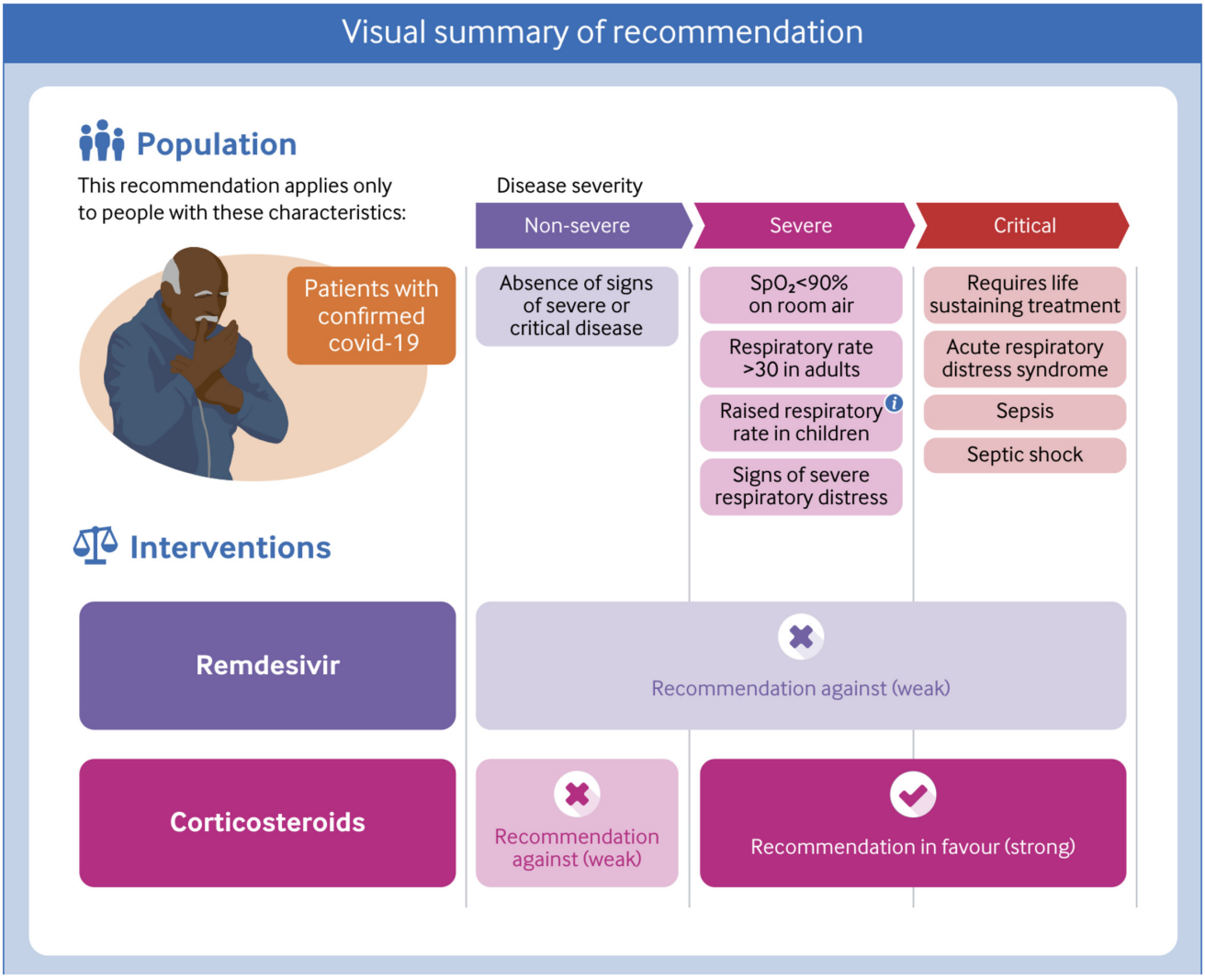
Sources of evidence

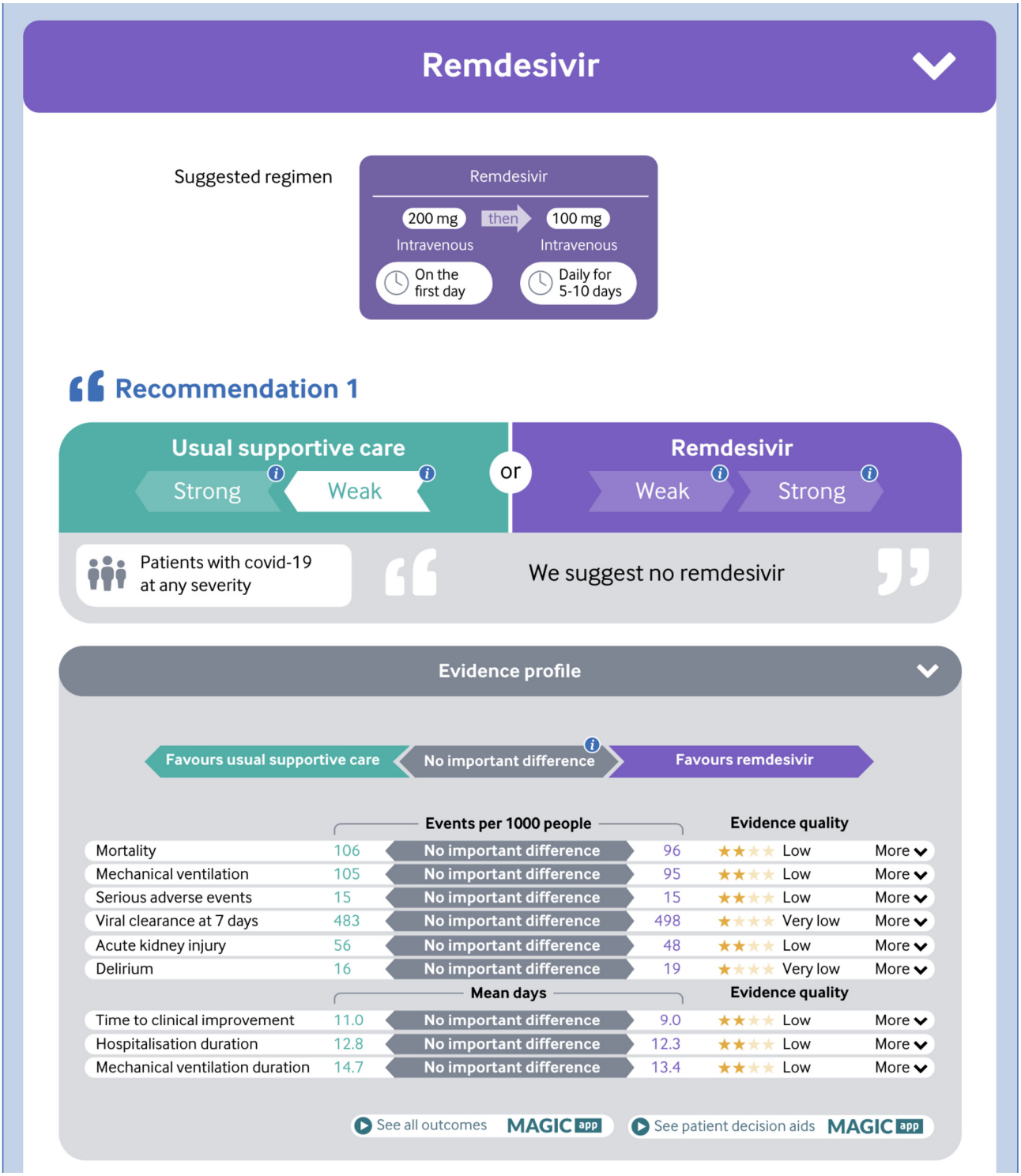
To create recommendations, the panel relied on evidence synthesised in a living network meta-analysis led by MAGIC.[4] While the investigators responsible for the meta-analyses rate the certainty of the evidence, this is re-assessed independently by the guideline panel.

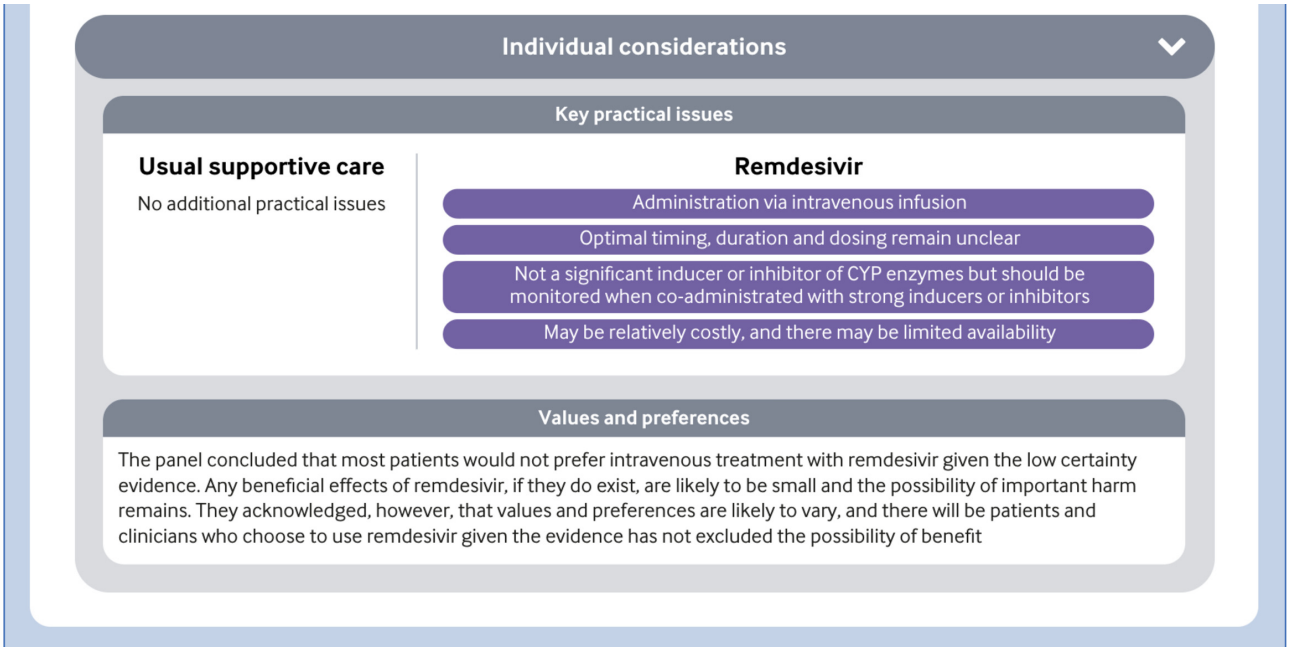
Derivation of absolute effects for drug treatments

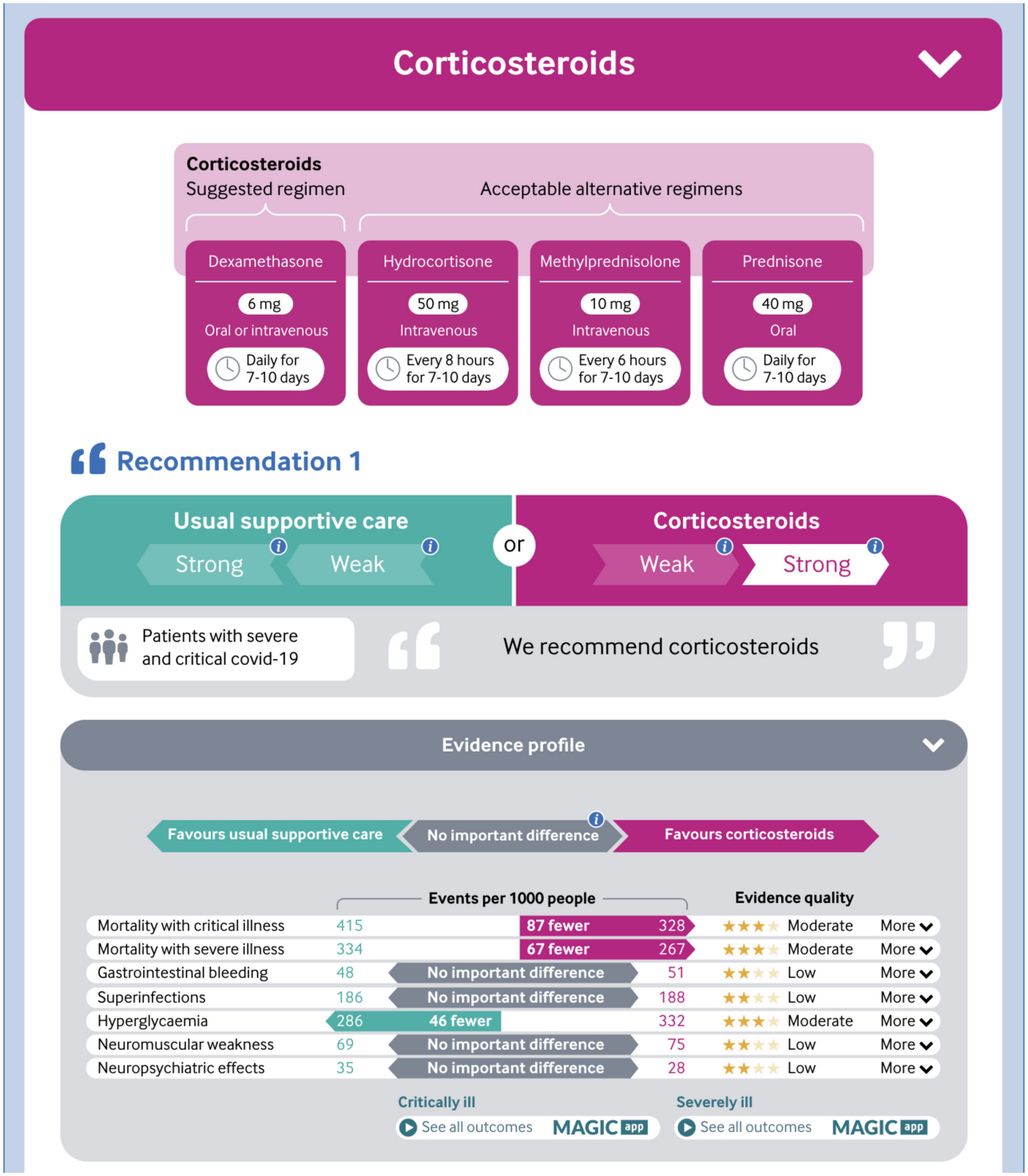
The control arm of the WHO SOLIDARITY trial, performed across a wide variety of countries and geographical regions, was identified by the remdesivir GDG panel as representing the most relevant source of evidence to make the baseline risk estimates for the outcomes of mortality and mechanical ventilation. The rationale for selecting the WHO SOLIDARITY trial was to reflect the overall prognosis of the global population for which the WHO guideline recommendations are made. In view of the study designs, the GDG determined that for other outcomes using the median or mean of all patients randomised to usual care across the included studies would provide the most reliable estimate of baseline risk.

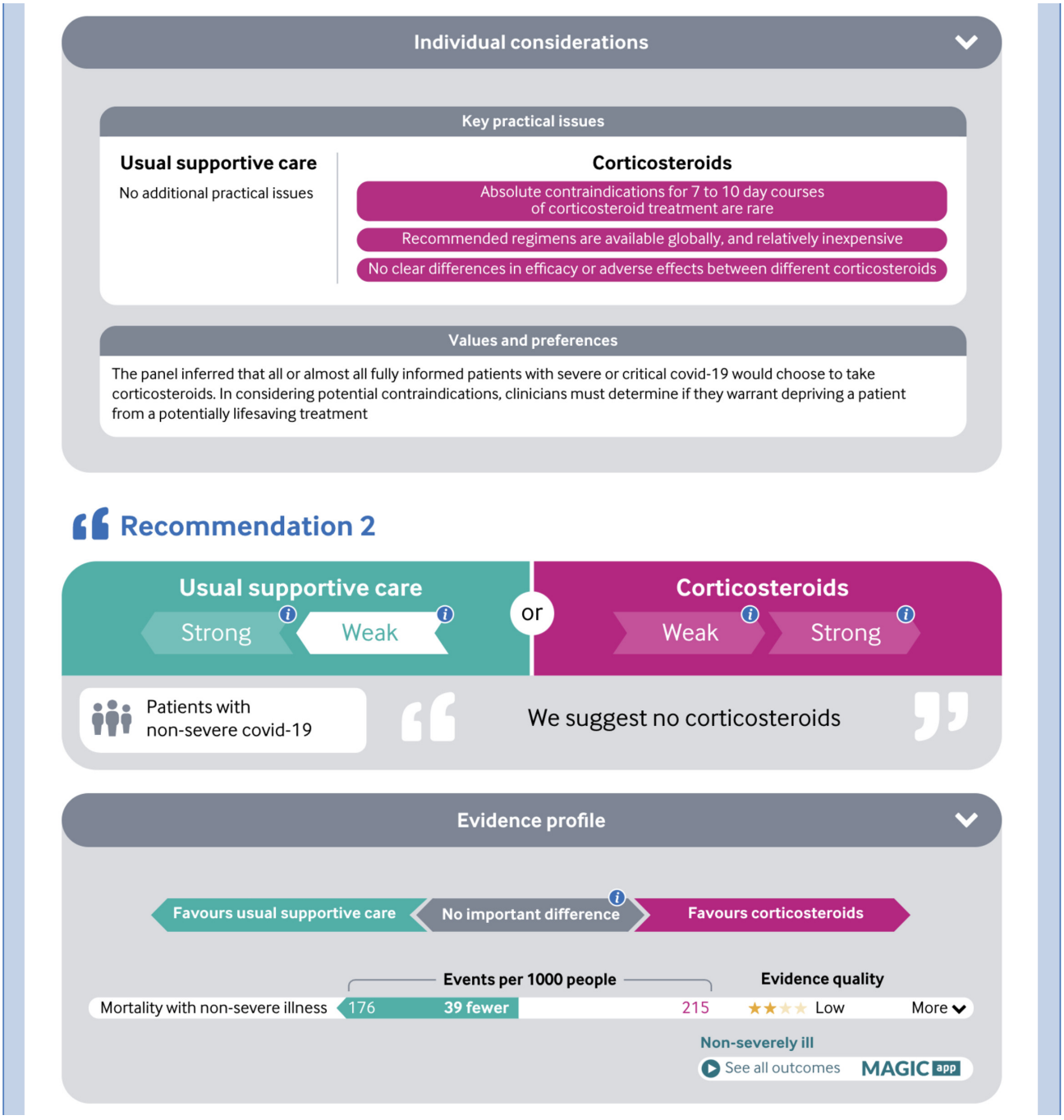
Of note, baseline risks, and thus absolute effects, may vary significantly geographically and over time. As such, users of this guideline may prefer estimating absolute effects by using local event rates.

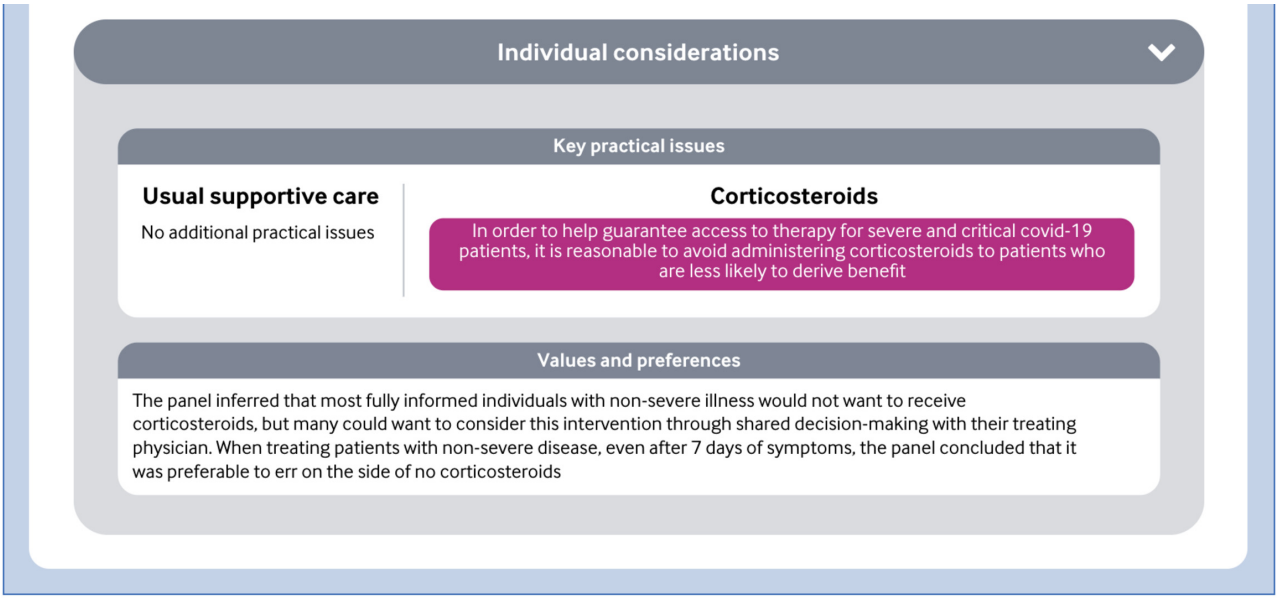












Who do the recommendations apply to?

The guideline for covid-19 therapeutics applies to hospitalised patients with covid-19. For some drugs (such as corticosteroids), recommendations may differ based on the severity of covid-19 disease. The GDG elected to use the WHO severity definitions based on clinical indicators, adapted from WHO covid-19 severity categorisation (see box 3).[9] These definitions avoid reliance on access to healthcare to define patient subgroups. The infographic illustrates these three disease severity groups and key characteristics to apply in practice.

Box 3: WHO definitions of disease severity for covid-19

- *Critical covid-19*—Defined by the criteria for acute respiratory distress syndrome (ARDS), sepsis, septic shock, or other conditions that would normally require the provision of life sustaining therapies such as mechanical ventilation (invasive or non-invasive) or vasopressor therapy.
- *Severe covid-19*—Defined by any of:
  - Oxygen saturation ‹90% on room air*
  - Respiratory rate ›30 breaths per minute in adults and children ›5 years old, ≥60 breaths/min in children ‹2 months old, ≥50 in children 2-11 months old, and ≥40 in children 1-5 years old
  - Signs of severe respiratory distress (accessory muscle use, inability to complete full sentences, and, in children, very severe chest wall indrawing, grunting, central cyanosis, or presence of any other general danger signs).
- *Non-severe covid-19*—Defined as absence of any signs of severe or critical covid-19.

*The panel noted that the oxygen saturation threshold of 90% to define severe covid-19 was arbitrary and should be interpreted cautiously when defining disease severity. For example, clinicians must use their judgment to determine whether a low oxygen saturation is a sign of severity or is normal for a given patient with chronic lung disease. Similarly, a saturation ›90-94% is abnormal, and can be an early sign of severe disease, if the patient is on a downward trend. Generally, if there is any doubt, the panel suggested erring on the side of considering the illness as severe.

The guidance

Remdesivir

The recommendation addressing remdesivir was informed by results from a systematic review and network meta-analysis that pooled data from four randomised trials with 7333 participants hospitalised for covid-19 (table 1).[2 10 -12] Of note, none of the included RCTs enrolled children or adolescents under the age of 19 years, and, although older people were included in the trials, their outcomes were not reported separately. Also, there is no pharmacokinetic or safety data on remdesivir for children. Given this, the applicability of this recommendation to children is currently uncertain.

Table 1 | Summary of trials and trial characteristics informing the remdesivir recommendation.

Study	No	Country	Mean age (years)	Severity (as per WHO criteria)	% IMV (at baseline)	Treatments (dose and duration)	Outcomes
Biegel (ACTT-1)	1063	USA, Europe, Asia	58.9	Non-severe (11.3%) Severe* (88.7%)	44.1%	Remdesivir IV (100 mg/day for 10 days)	-Mortality -Adverse events -Time to clinical improvement
Spinner (SIMPLE MODERATE)†	596	USA, Europe, Asia	56-58	Non-severe (100%)	0%	Remdesivir IV (200 mg at day 1, then 100 mg for 4 or 9 days)	-Mortality -Time to clinical improvement -Duration of hospitalisation -Mechanical ventilation -Adverse events
Pan (SOLIDARITY)	5451	Worldwide	‹50 35% 50-70 47% ›70 18%	Non-severe (24%) Severe** (67%) Critical (9%)	8.9%	Remdesivir IV (200 mg at day 1, then 100 mg days 2-10)	-Mortality -Mechanical ventilation
Wang	237	China	65	Severe*** (100%)	16.1%	Remdesivir IV (100 mg/day for 10 days)	-Mortality -Mechanical ventilation -Adverse events -Viral clearance -Duration of hospitalisation -Duration of ventilation -Time to clinical improvement

IMV = invasive mechanical ventilation. No = number of patients. IV = intravenous.

Severity criteria based on WHO definitions unless otherwise stated. * defined severe as SPO2 ‹94% on room air or respiratory rate ›24 breaths/min; ** defined severe as requiring oxygen support; *** defined severe as SpO2 ‹94% on room air.

† Only SIMPLE MODERATE was included in the analysis, as SIMPLE SEVERE (Goldman et al) did not have a placebo or usual care arm.

Understanding the recommendation on remdesivir

We suggest against administering remdesivir in addition to usual care for the treatment of patients hospitalised with covid-19, regardless of disease severity (weak or conditional recommendation)

When moving from evidence to the conditional recommendation against the use of remdesivir for patients with covid-19, the panel emphasised the evidence of possibly no effect on mortality, need for mechanical ventilation, time to clinical improvement, and other patient-important outcomes, albeit of low certainty; it also noted the anticipated variability in patient values and preferences and other contextual factors, such as resource considerations, accessibility, feasibility and impact on health equity (see below).

Importantly, given the low certainty evidence for these outcomes, the panel concluded that the evidence did not prove that remdesivir has no benefit; rather, there is no evidence based on currently available data that it does improve patient-important outcomes. Especially given the costs and resource implications associated with remdesivir, but consistent with the approach that should be taken with any new drug, the panel felt the responsibility should be on demonstrating evidence of efficacy, which is not established by the currently available data.

Balance of benefit and harm—The GDG panel found a lack of evidence that remdesivir improved outcomes that matter to patients such as reduced mortality, need for mechanical ventilation, time to clinical improvement, and others. There was no evidence of increased risk of serious adverse events in patients receiving remdesivir, at least from the included trials. Further pharmacovigilance is required to confirm this, as serious adverse events are commonly underreported and rare events would be missed, even in large RCTs.

Data from the network meta-analysis indicated that a subgroup of people with non-critical disease might benefit from remdesivir. However, the panel judged the credibility in this subgroup analysis to be insufficient to make subgroup recommendations.[13] Important factors influencing this decision included a lack of a priori hypothesised direction of subgroup effect by trial investigators, little or no previously existing supportive evidence for the subgroup finding, and relatively arbitrary cut points used to examine the subgroups of interest. The overall low certainty evidence for the benefits and harms of remdesivir, driven by risk of bias and imprecision limitations, also contributed to the judgement (see WHO guidance and MAGICapp linked from box 1 for full details). The panel highlighted that, despite the conditional recommendation against remdesivir, they support further enrolment into RCTs evaluating remdesivir, especially to provide higher certainty of evidence for specific subgroups of patients. The panel had a priori requested analyses of other important subgroups of patients, including children and older people, but there were no data to address these groups specifically. None of the included RCTs enrolled children, and, although older people were included in the trials, their outcomes were not reported separately. Also, there are no pharmacokinetic or safety data on remdesivir for children. Given this, the applicability of this recommendation to children is currently uncertain.

Values and preferences—The panel inferred that most patients would be reluctant to use remdesivir given that the evidence left high uncertainty regarding effects on mortality and the other prioritised

outcomes. This was particularly so as any beneficial effects of remdesivir, if they do exist, are likely to be small, and the possibility of important harm remains. The panel acknowledged, however, that values and preferences are likely to vary, and there will be patients and clinicians who choose to use remdesivir given that the evidence has not excluded the possibility of benefit.

Resource implications, feasibility, equity, and human rights—A novel therapy typically requires higher certainty evidence of important benefits than currently available for remdesivir, preferably supported wherever possible by cost-effectiveness analysis. In the absence of this information, the GDG raised concerns about opportunity costs and the importance of not drawing attention and resources away from best supportive care or the use of corticosteroids in severe covid-19. It was noted that, currently, remdesivir is administered only by the intravenous route and global availability is limited.

Practical issues—Its use is contraindicated in those with liver dysfunction (ALT >5 times normal at baseline) or renal dysfunction (eGFR <30 mL/minute). To date, it can only be administered intravenously, and it has relatively limited availability.

Corticosteroids (published 4 September 2020)

On 17 July 2020 the panel reviewed evidence from eight RCTs (7184 patients)[14-18] evaluating systemic corticosteroids versus usual care in treatment of covid-19, seven of which reported mortality data by subgroup of illness severity.[4] (Mortality data from one trial, GLUCOCOVID, were not incorporated in the summary of finding for mortality because the mortality outcome data were not available by subgroup.) The panel did not consider transdermal or inhaled administration of corticosteroids, high dose or long term regimens, or prophylaxis. Box 4 outlines the evidence. The panel did not reach consensus on recommendation 1, which required a vote. The second recommendation was made by consensus. More details on the underlying panel discussions can be found in the WHO guidance document (see box 1 for link).

Box 4: Outline of the evidence on systemic corticosteroids for treating covid-19

While six trials evaluated systemic corticosteroids exclusively in critically ill patients, the RECOVERY trial enrolled hospitalised patients with covid-19 and reported mortality data by subgroup, whereas the smaller GLUCOCOVID trial, which also enrolled hospitalised patients, did not. The panel considered the results of a subgroup analysis of the RECOVERY trial suggesting that the relative effects of systemic corticosteroids varied as a function of the level of respiratory support received at randomisation. On the basis of the peer reviewed criteria for credible subgroup effects,[13] the panel determined that the subgroup effect was sufficiently credible to warrant separate recommendations for severe and non-severe covid-19.

- *Population*—There were data from 1703 critically ill patients in seven trials. RECOVERY, the largest of the seven trials randomised 6425 hospitalised patients in the UK (2104 were randomised to dexamethasone and 4321 were randomised to usual care). At the time of randomisation, 16% were receiving invasive mechanical ventilation or extracorporeal membrane oxygenation, 60% were receiving oxygen only (with or without non-invasive ventilation), and 24% were receiving neither. The mortality data from six smaller trials included approximately 700 critically ill patients (definitions of critical illness varied across studies) enrolled up to 9 June 2020, approximately 80% were invasively mechanically ventilated; approximately 50% were randomised to receive corticosteroid therapy, and 50% randomised to no corticosteroid therapy. RECOVERY was the only trial reporting mortality data for patients with severe and non-severe covid-19 (3883 patients with severe and 1535 patients with non-severe covid-19). Because the mortality data from one trial (GLUCOCOVID, n=63) was not reported separately for severe and non-severe covid-19, the panel reviewed only the data pertaining to the outcome of mechanical ventilation from this trial.
- *Interventions*—RECOVERY evaluated the effects of dexamethasone 6 mg given once daily (oral or intravenous) for up to 10 days. Other corticosteroid regimens included dexamethasone 20 mg daily for 5 days followed by 10 mg daily for 5 days (two trials, DEXA-COVID and CoDEX); hydrocortisone 200 mg daily for 4-7 days followed by 100 mg daily for 2-4 days and then 50 mg daily for 2-3 days (one trial, CAPE-COVID); hydrocortisone 200 mg daily for 7 days (one trial, REMAP-CAP); methylprednisolone 40 mg every 12 hours for 5 days (one trial, Steroids-SARI); and methylprednisolone 40 mg every 12 hours for 3 days and then 20 mg every 12 hours for 3 days (one trial, GLUCOCOVID). Seven of the trials were conducted in individual countries (Brazil, China, Denmark, France, Spain), while REMAP-CAP was an international study (recruiting in 14 European countries, Australia, Canada, New Zealand, Saudi Arabia, and UK).
- *Outcomes*—All trials reported mortality 28 days after randomisation, except for one trial at 21 days and the another at 30 days.

Understanding the recommendations on corticosteroids

Recommendation 1: We recommend systemic corticosteroids rather than no systemic corticosteroids for the treatment of patients with severe and critical covid-19 (strong recommendation)

Who does it apply to? This recommendation applies to patients with severe and critical covid-19. The panel judged that all or almost all fully informed patients with severe covid-19 would choose to take systemic corticosteroids. The recommendation should apply to patients with severe and critical covid-19 even if they cannot be hospitalised or receive oxygen because of resource limitations.

The applicability of the recommendation is less clear for populations that were under-represented in the considered trials, such as children, patients with tuberculosis, and those who are immunocompromised. In considering potential contraindications to short term systemic corticosteroids in such patients, clinicians must determine if they warrant depriving a patient of a potentially lifesaving therapy. Clinicians should exercise caution in use of corticosteroids in patients with diabetes or underlying immunocompromise. The panel was confident that clinicians using these guidelines would be aware of additional potential side effects and contraindications to systemic corticosteroid therapy, which may vary geographically in function of endemic microbiological flora.

Balance of benefit and harm—Ultimately, the panel made its recommendation on the basis of the moderate certainty evidence of a 28 day mortality reduction of 8.7% in the critically ill and 6.7% reduction in patients with severe covid-19 who were not critically ill. Systemic corticosteroids compared with no corticosteroid therapy probably reduce the risk of 28 day mortality in critically ill patients with covid-19 (moderate certainty evidence; relative risk 0.80 (95% confidence interval 0.70 to 0.91); absolute effect estimate 87 fewer deaths per 1000 patients (95% CI 124 fewer to 41 fewer)). In patients with severe covid-19, systemic corticosteroids also probably reduce the risk of death (moderate certainty evidence; relative risk 0.80 (0.70 to 0.92); absolute effect estimate 67 fewer deaths per 1000 patients (100 fewer to 27 fewer)). The effects of systemic corticosteroids on other outcomes are described in the summary of findings.

Overall, the panel has high certainty that the adverse effects when considered together are sufficiently limited in importance and frequency and suggested that corticosteroids administered in these doses for 7-10 days are not associated with an increased risk of adverse events, beyond likely increasing the incidence of

hyperglycaemia (moderate certainty evidence; absolute effect estimate 46 more per 1000 patients (23 more to 72 more)) and hypernatraemia (moderate certainty evidence; 26 more per 1000 patients (13 more to 41 more)). In contrast with new agents proposed for covid-19, clinicians have a vast experience of systemic corticosteroids, and the panel was reassured by their overall safety profile.

Values and preferences—The panel took an individual patient perspective to values and preferences but, given the burden of the pandemic for healthcare systems globally, also placed a high value on resource allocation and equity. The benefits of corticosteroids on mortality was deemed of critical importance to patients, with little or no anticipated variability in their preference to be offered treatment if severely ill from covid-19.

Resource implications, feasibility, equity, and human rights—Systemic corticosteroids are low cost, easy to administer, and readily available globally.[19] Dexamethasone and prednisolone are among the most commonly listed medicines in national essential medicines lists; listed by 95% of countries. Accordingly, systemic corticosteroids are among a relatively small number of interventions for covid-19 that have the potential to reduce inequities and improve equity in health. Those considerations influenced the strength of this recommendation.

Acceptability—The ease of administration, the relatively short duration of a course of systemic corticosteroid therapy, and the generally benign safety profile of systemic corticosteroids administered for up to 7-10 days led the panel to conclude that the acceptability of this intervention was high.

Recommendation 2: We suggest not to use corticosteroids in the treatment of patients with non-severe covid-19 (weak or conditional recommendation)

Who does it apply to? This recommendation applies to patients with non-severe disease regardless of their hospitalisation status. The panel noted that patients with non-severe covid-19 would not normally require acute care in hospital or respiratory support, but in some jurisdictions these patients may be hospitalised for isolation purposes only, in which case they should not be treated with systemic corticosteroids. Several specific circumstances were considered.

- Systemic corticosteroids should not be stopped for patients with non-severe covid-19 who are already treated with systemic corticosteroids for other reasons (such as patients with chronic obstructive pulmonary disease or chronic autoimmune disease).
- If the clinical condition of patients with non-severe covid-19 worsens (that is, increase in respiratory rate, signs of respiratory distress or hypoxaemia) they should receive systemic corticosteroids (see recommendation 1).
- Pregnancy: antenatal corticosteroid therapy may be administered for pregnant women at risk of preterm birth from 24 to 34 weeks' gestation when there is no clinical evidence of maternal infection and adequate childbirth and newborn care are available. In cases where the woman presents with mild or moderate covid-19, the clinical benefits of antenatal corticosteroid might outweigh the risks of potential harm to the mother. In this situation, the balance of benefits and harms for the woman and the preterm newborn should be discussed with the woman to ensure an informed decision, as this assessment may vary depending on the woman's clinical condition, her wishes and those of her family, and available healthcare resources.
- Endemic infections that may worsen with corticosteroids should be considered. For example, for *Strongyloides stercoralis* hyperinfection associated with corticosteroid therapy, diagnosis or empiric treatment may be considered in endemic areas if steroids are used.

Balance of benefit and harm—Systemic corticosteroids may increase the risk of 28 day mortality (low certainty evidence; relative risk 1.22 (95% CI 0.93 to 1.61); absolute effect estimate 39 more per 1000 patients (95% CI 12 fewer to 107 more)). The certainty of the evidence for this specific subgroup was downgraded due to serious imprecision (that is, the evidence does not allow to rule out a mortality reduction) and risk of bias due to lack of blinding. The effects of systemic corticosteroids on other outcomes are described in the summary of findings (infographic and links to MAGICapp).

Values and preferences—The weak or conditional recommendation was driven by likely variation in patient values and preferences. The panel judged that most individuals with non-severe illness would decline systemic corticosteroids. However, many may want them after shared decision making with their treating physician.

Resource implications, feasibility, equity, and human rights—To help guarantee access to systemic corticosteroids for patients with severe and critical covid-19, it is reasonable to avoid their administration to patients who, given the current evidence, do not seem to derive any benefit from this intervention

Uncertainties, emerging evidence, and future research

The guideline recommendations for covid-19 therapeutics demonstrate remaining uncertainties concerning treatment effects for all outcomes of importance to patients. There is also a need for better evidence on prognosis and values and preferences of patients with covid-19. Here we outline key uncertainties for remdesivir identified by the GDG, adding to those for corticosteroids in the first version of the living guideline. These uncertainties may inform future research—that is, the production of more relevant and reliable evidence to inform policy and practice. We also outline emerging evidence in the rapidly changing landscape of trials for covid-19.

Uncertainties for remdesivir

These include effects on:

- Critical outcomes of interest, particularly those that impact resource allocation, such as the need for mechanical ventilation, duration of mechanical ventilation, and duration of hospitalisation
- Specific subgroups, such as different severities of illness, different time (days) since onset of illness, children and older adults, pregnant women, duration of therapy
- Long term outcomes (such as 1-year endpoint) examining mortality or long term quality of life
- Long term safety and rare but important side effects
- Patient-reported outcomes such as symptom burden
- Outcomes when used in combination with other agents such as, but not limited to, corticosteroids
- Impact on viral shedding, viral clearance, patient infectivity.

For remdesivir, 36 trials have been registered and six are completed. The median planned sample size of these trials is 260 (interquartile range 80 1062) (fig 1). Further details of all registered trials are in appendix 2.[1]

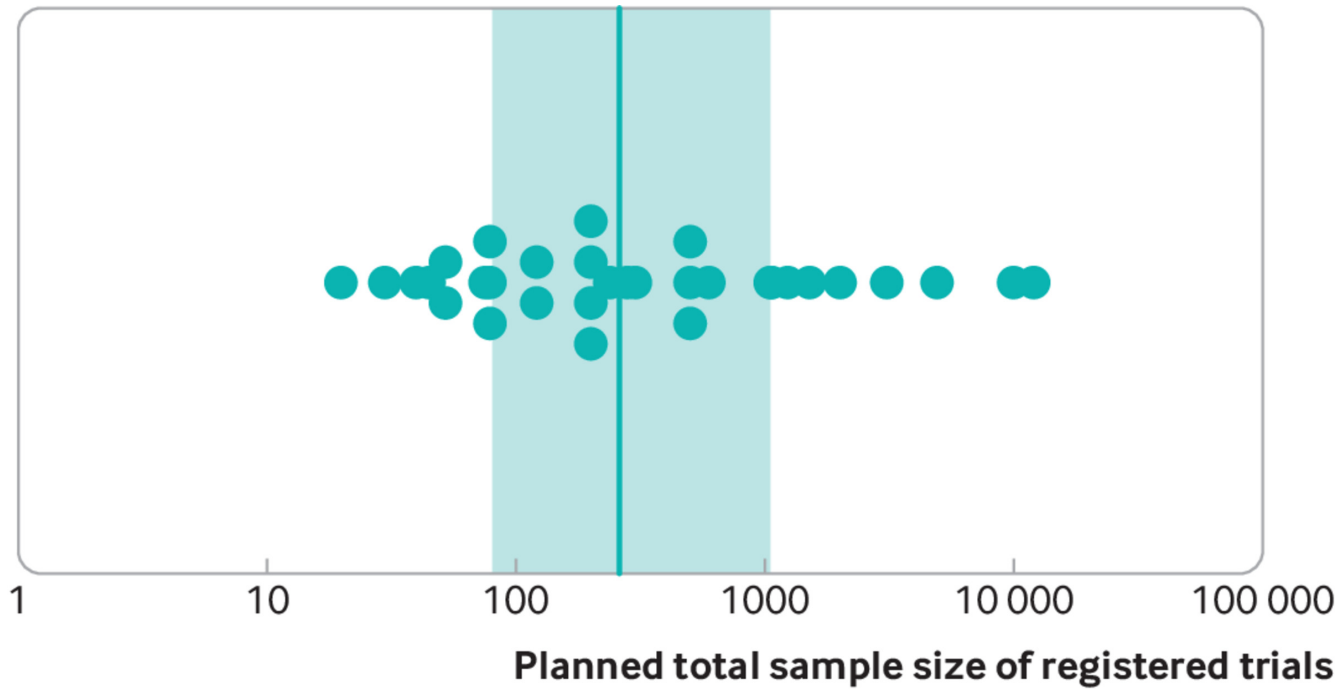


Fig 1 | Sample size of remdesivir randomised controlled trials

Uncertainties for corticosteroids

These include effects on:

- Long term mortality and functional outcomes in covid-19 survivors
- Patients with non-severe covid-19 (that is, pneumonia without hypoxaemia)
- When used in combination with additional therapies for covid-19, such as novel immunomodulators. It will become increasingly important to ascertain how these interact with systemic corticosteroids. All investigational therapies for severe and critical covid-19 (including remdesivir) should be compared with systemic corticosteroids or evaluated in combination with systemic corticosteroids versus systemic corticosteroids alone.
- Immunity and the risk of a subsequent infection, which may affect the risk of death after 28 days.
- By different steroid preparation, dosing, and optimal timing of drug initiation.

Emerging evidence

The unprecedented volume of planned and ongoing studies for covid-19 interventions—2801 RCTs as of 1 November 2020—implies that more reliable and relevant evidence will emerge to inform policy and practice.[1] An overview of registered and ongoing trials for covid-19 therapeutics is available from the Infectious Diseases Data Observatory, through their living systematic review of covid-19 clinical trial registrations[1] and WHO website https://www.covid-nma.com/dataviz/.

Although most of these studies are small and of variable methodological quality, some large, international platform trials (such as RECOVERY, SOLIDARITY, and DISCOVERY) are better equipped to provide robust evidence for several potential treatment options.[20] Such trials can also adapt their design, recruitment strategies, and selection of interventions based on new insights.

How patients were involved in the creation of this article

The guideline panel included four patients who have had covid-19. Their perspectives were crucial in considering the values and preferences associated with remdesivir and corticosteroids.

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Funding: No specific funding was provided for this guideline, with MAGIC providing pro-bono contributions and support to WHO in the context of the COVID-19 pandemic.

Competing interests: All guideline panel members have completed the WHO interest disclosure form. All authors have completed the *BMJ* Rapid Recommendations interest of disclosure form. The WHO, MAGIC and *The BMJ* judged that no panel member had any financial conflict of interest. Professional and academic interests are minimised as much as possible, while maintaining necessary expertise on the panel to make fully informed decisions. MAGIC and *TheBMJ* assessed declared interests from other co-authors of this publication and found no conflicts of interests.

Provenance and peer review: This publication was commissioned by *The BMJ* in partnership with WHO and the MAGIC Evidence Ecosystem Foundation, in the context of the *BMJ* Rapid Recommendations. Pre-publication internal and external peer-review managed by WHO, and internal review at *The BMJ*. Post-publication review on bmj.com on rapid responses and through MAGICapp.

We thank all the following collaborators who contributed to this endeavour, as detailed in the WHO guidance (see link in box 1)

- World Health Organisation (WHO) Secretariat for Therapeutics and COVID-19
- WHO Rapid Evidence Appraisal for COVID-19 Therapies (REACT) Working Group
- External reviewers for WHO

We also thank

- The living systematic review and network meta-analysis team, led by investigators Dr Reed Siemienuk and Romina Brignardello-Petersen at McMaster University, Canada
- BMJ editorial team with Navjoyt Ladher (editor BMJ Education), Will Stahl-Timmins (designer infographics) and Greg Cotton (technical editor) of this living guideline publication in *The BMJ*
- Brittany Maguire, Philippe Guerin, and Sumayyah Rashan for providing up to date corticosteroid data from the Infectious Diseases Data Observatory (IDDO) living systematic review for covid-19 clinical trial registration (https://www.iddo.org/research-themes/covid-19/live-systematic-clinical-trial-review)

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