Overview of information available to support the development of medical countermeasures and interventions against COVID-19

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It is based on open-access publications (scientific journals and preprint databases, communications by WHO and OIE, health authorities and companies) in English language.

Please note that the present version has not been submitted to any peer-review process. Any comment / addition that can help improve the contents of this review will be most welcome.

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List of abbreviations

AAK1	AP2-associated protein kinase 1
ACE2	angiotensin-converting enzyme 2
AI	artificial intelligence
ALB	albumin
ALT	alanine aminotransferase
AMPs	Antimicrobial peptides
ARDS	acute respiratory distress syndrome
AST	aspartate aminotransferase
AT2	type II alveolar cells
BMI	body mass index
CI	confidence interval
CNS	central nervous system
CoV	coronavirus
CPK	creatine phosphokinase
CRP	C-reactive protein
CSF	cerebrospinal fluid
CT	computed tomography
ELISA	enzyme-linked immunosorbent serologic assay
GISAID	Global Initiative on Sharing All Influenza Data
HCW	health care workers
IC50	half maximal inhibitory concentration
IFN	interferon
ISG	IFN-stimulated genes
mAb	monoclonal antibody
MERS	Middle East respiratory syndrome
MHV	murine hepatitis virus
MOI	multiplicity of infection
MSCs	mesenchymal stem cells
N	nucleocapsid
NAb	neutralizing antibody
NCIP	novel coronavirus-infected pneumonia
NK	natural killer
N.R.	not reported
PAD	Primary Antibody Deficiencies
PCR	polymerase chain reaction
pfu	plaque-forming unit
PPE	personal protective equipment
PRNT	plaque-reduction neutralization test
R&D	research and development
RBD	receptor-binding domain
RT-PCR	real-time polymerase chain reaction
S	spike
SAA	serum amyloid A
SARS	severe acute respiratory syndrome
WHO	World Health Organization

Introduction

Coronaviruses are common human pathogens, causing generally-mild acute respiratory illnesses known as the common cold (Wu Eurosurv 2020, see ***below***). Prior to December 2019 when clusters of pneumonia cases with unknown aetiology were detected in Wuhan, China, only two additional strains of coronaviruses had caused outbreaks of severe acute respiratory disease in humans: the severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East respiratory syndrome coronavirus (MERS-CoV). On 9 January 2020, a novel coronavirus, 2019-nCoV (temporary name), was officially identified as the cause of an outbreak of viral pneumonia in Wuhan (https://www.who.int/china/news/detail/09-01-2020-who-statement-regarding-cluster-of-pneumonia-cases-in-wuhan-china). In the following weeks, the virus spread rapidly within China, and an increasing number of cases appeared in other countries. On January 30th 2020, the International Health Regulations (2005) Emergency Committee agreed that the outbreak meets the criteria for a Public Health Emergency of International Concern (https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)). The disease was named COVID-19 by WHO on February 11 2020 (https://www.who.int/dg/speeches/detail/who-director-general-s-remarks-at-the-media-briefing-on-2019-ncov-on-11-february-2020), and the virus named SARS-CoV-2 by the International Committee on Virus Taxonomy on the same day (Coronaviridae Study Group of the International Committee on Taxonomy of Viruses Nat Microbiol 2020, see ***below***). Subsequently, a group of virologists in China suggested renaming SARS-CoV-2 as human coronavirus 2019 (HCoV-19), considering that such a name would distinguish the virus from SARS-CoV and keep it consistent with the WHO name of the disease it causes, COVID-19 (Jiang Lancet 2020, see ***below***). Virus naming long remained controversial (Voice from China Chin Med J 2020, see ***below***) and in the scientific literature, the virus can be referred to by these different names, even though Wu, Ho et al. (Lancet 2020, see ***below***) suggested keeping SARS-CoV-2 as its name.

On March 11 2020, WHO characterised COVID-19 as a pandemic (https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020).

The epidemic progressed very quickly in the weeks that followed this announcement. As of April 28, 2020, 12:00 CET, according to WHO, a total of 2 883 603 cases has been confirmed globally, including 198 842 deaths. The vast majority of the cases have been reported by other countries than China (e.g. U.S.A. 931 698, Spain 207 634 and Italy 197 675 vs. China 84 341).

The virus

Coronaviruses

Coronaviruses (CoVs) are enveloped, positive-sense, single-stranded RNA viruses that belong to the subfamily Coronavirinae, family Coronavirdiae, order Nidovirales. The virion has a nucleocapsid composed of genomic RNA and phosphorylated nucleocapsid (N) protein, which is buried inside phospholipid bilayers and covered by spike proteins (Li J Med Virol 2020, see ***below***). The membrane (M) protein (a type III transmembrane glycoprotein) and the envelope (E) protein are located among the spike (S) proteins in the virus envelope. CoVs were given their name based on a characteristic crown-like appearance.

There are four genera of CoVs, namely, Alphacoronavirus (αCoV), Betacoronavirus (βCoV), Deltacoronavirus (δCoV), and Gammacoronavirus (γCoV) (Chan Em Micr Inf 2020, see ***below***). Evolutionary analyses have shown that bats and rodents are the gene sources of most αCoVs and βCoVs, while avian species are the gene sources of most δCoVs and γCoVs. CoVs have repeatedly crossed species barriers and some have emerged as important human pathogens.

The genomic RNA is used as template to directly translate polyprotein (pp) 1a/1ab, which encodes non-structural proteins to form the replication-transcription complex (RTC) in a double-membrane vesicles (Chen J Med Vir 2020, see

below). Subsequently, a nested set of subgenomic RNAs are synthesized by the RTC in a manner of discontinuous transcription. The first ORFs (ORF1a/b), about two-third of the whole genome length, encode 16 non-structural proteins (nsp1-16). Other ORFs on the one-third of the genome near the 3'-terminus encodes the main structural proteins: S, M, E, and N proteins. Besides these four main structural proteins, CoVs encode special structural and accessory proteins. All the structural and accessory proteins are translated from the subgenomic RNAs of CoVs.

Prasad (Ind J Med Res 2020, see *below*) presented electron microscopy images of the virus (Figure 1). The images revealed the presence of stalk-like projections ending in round peplomeric structures typical of a coronavirus particle.

Figure 1 Transmission electron microscopy imaging of SARS-CoV-2 (from Prasad Ind J Med Res 2020)

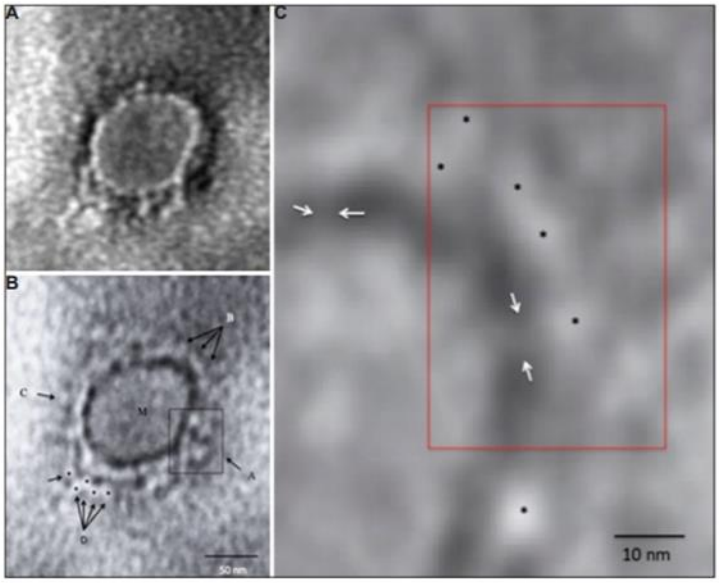


Figure. Transmission electron microscopy imaging of COVID-19. (**A**) A representative negative-stained COVID-19 particle showing morphodiagnostic features of family *Coronaviridae*. (**B**) Defocussed image of the same particle resolving the virus envelope glycoprotein morphology in finer details. The boxed area A shows a tetramer-like aggregate of four distinct peplomers, arrows shown by B show a more orthodox morphology of coronavirus surface projections. M indicates the matrix of the virus particle. C shows a distinct 'peplomer head' with negative stain silhouette. The area D is interesting as possible linear projections could be imaged. Five distinct peplomers could be imaged as shown by the arrows. (**C**) A highly magnified processed image for pixel corrections shows a distinct evidence of direct 'stalk' connecting the peplomer to the virion surface. The peplomers are shown with asterisk and the stalk with an arrow. Magnification bars are built into the micrographs.

SARS-CoV-2 is a betacoronavirus

On January 3, 2020, the first complete genome of the novel β genus coronaviruses (2019-nCoV, subsequently named SARS-CoV-2) was identified in samples of bronchoalveolar lavage fluid from a patient from Wuhan (http://weekly.chinacdc.cn/en/article/id/a3907201-f64f-4154-a19e-4253b453d10c and Wu Nature 2020, see *below*). A viral genome sequence was released via the community online resource virological.org on 10 January (Wuhan-Hu-1, GenBank accession number MN908947 (http://virological.org/t/novel-2019-coronavirus-genome/319). Additional sequences were rapidly obtained by other groups and complete genomes were submitted to GISAID (see for instance, Zhu New Engl J Med 2020 *below*).

SARS-CoV-2 falls into the genus *betacoronavirus*, which includes CoVs discovered in humans, bats, and other wild animals (SARS-CoV, bat SARS-like CoV, and others). As illustrated in Table 1 below, additional studies, based on subsequent virus isolates, confirmed that the virus is phylogenetically closest to bat SARS-like CoV (SL-ZC45 and SL-CoVZXC21).

Table 1 SARS-CoV-2 sequence homology with other coronaviruses

% homology with				reference
SARS	**MERS**	**bat SARS-like CoV***	**BatCoV RaTG13**	
N.R.	N.R.	89.1%	N.R.	Wu Nature 2020, see *below*

% homology with				reference
SARS	MERS	bat SARS-like CoV*	BatCoV RaTG13	
79.0%	51.8%	87.6-87.7%		Ren Chinese Med J 2020, see ***below***
82%	N.R.	89%	N.R.	Jiang Em Micr Inf 2020, see ***below***
82%	N.R.	89%	N.R.	Chan Em Micr Inf 2020, see ***below***
79%	50%	88%	N.R.	Lu Lancet 2020, see ***below***
N.R.	N.R.	N.R.	96.3%	Paraskevis Infect Genet Evol 2020, see ***below***
<80%	N.R.	N.R.	96.2%	Zhou Nature 2020, see ***below***
79.7%	N.R.	87.9%	N.R.	Chen Em Micr Inf 2020, see ***below***

** bat-SL-CoV-ZC45 and/or bat-SL-CoV-ZXC21*

The observation that SARS-CoV-2 isolates have a single intact open reading frame gene 8 is a further indicator of bat-origin CoVs. In addition, although closely related to BatCoV RaTG13 sequence throughout the genome (sequence similarity 96.3%), SARS-CoV-2 shows discordant clustering with the Bat_SARS-like coronavirus sequences (Paraskevis Infect Genet Evol 2020, see ***below;*** Lu Lancet 2020, see ***below***). Specifically, in the 5'-part spanning the first 11,498 nucleotides and the last 3'-part spanning 24,341-30,696 positions, SARS-CoV-2 and RaTG13 formed a single cluster with Bat_SARS-like coronavirus sequences, whereas in the middle region spanning the 3'-end of ORF1a, the ORF1b and almost half of the spike regions, SARS-CoV-2 and RaTG13 grouped in a separate distant lineage within the **sarbecovirus** branch. Consequently, the levels of genetic similarity between SARS-CoV-2 and RaTG13 suggest that the latter does not provide the exact variant that caused the outbreak in humans, but the hypothesis that SARS-CoV-2 has originated from bats is very likely.

Genome structure

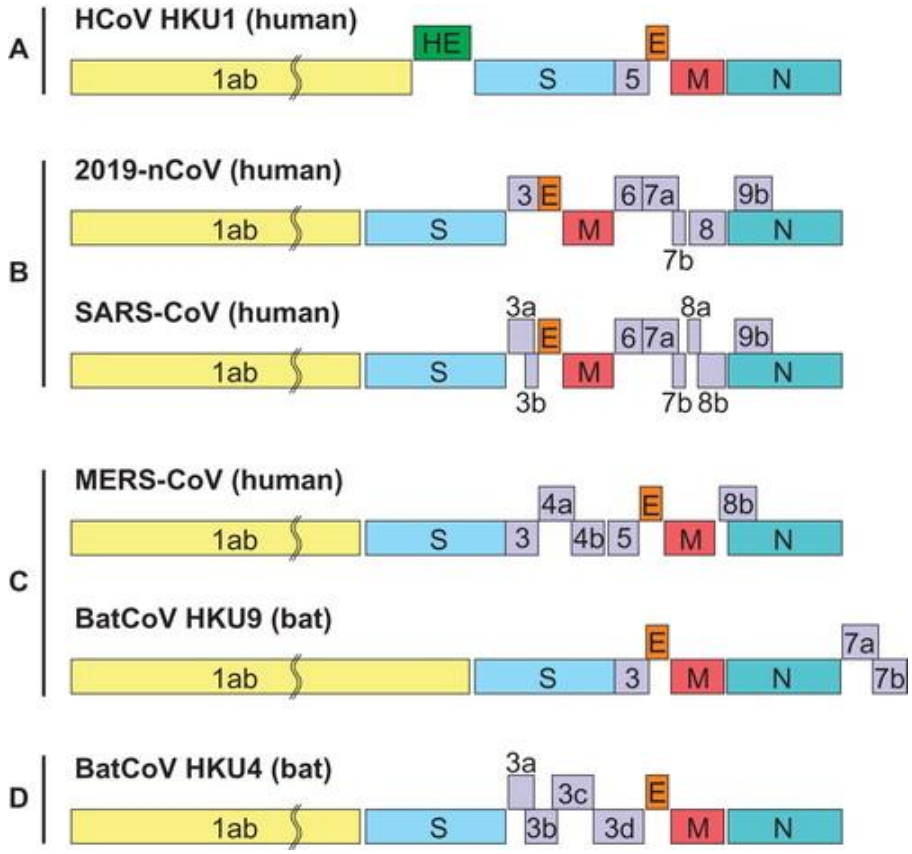
Similar to other βCoVs, the SARS-CoV-2 genome contains two flanking untranslated regions and a single long open reading frame encoding a polyprotein (Chan Em Micr Inf 2020, see ***below)***. The SARS-CoV-2 genome is arranged in the order of 5'-replicase (orf1/ab)-structural proteins [S-E-M-N]−3' and lacks the hemagglutinin-esterase gene which is characteristically found in lineage A β-CoVs, as illustrated in Figure 2.

The genome of SARS-CoV-2 encodes four major structural proteins [spike (S), envelope (E), membrane (M), and nucleocapsid (N)], approximately 16 nonstructural proteins (nsp1–16), and five to eight accessory proteins (Jiang Trends Imm 2020, see ***below***). Among them, the S protein plays an essential role in viral attachment, fusion, entry, and transmission. It comprises an N-terminal S1 subunit responsible for virus-receptor binding and a C-terminal S2 subunit responsible for virus-cell membrane fusion. The S1 subunit contains a signal peptide, followed by an N-terminal domain (NTD) and receptor-binding domain (RBD), while the S2 subunit contains conserved fusion peptide, heptad repeat 1 and 2, transmembrane domain, and cytoplasmic domain.

Remarkably, orf3b encodes a completely novel short protein. Furthermore, new orf8 likely encodes a secreted protein with an alpha-helix, following with a beta-sheet(s) containing six strands.

Of note, a manuscript by Tran Thi Nhu Thao on Biorixv (https://www.biorxiv.org/content/10.1101/2020.02.21.959817v1) described a reverse-genetics platform for SARS-CoV-2, consisting of a yeast-based synthetic genomics platform. Viral subgenomic fragments were generated using viral isolates, cloned viral DNA, clinical samples, or synthetic DNA, and reassembled in one step in Saccharomyces cerevisiae using transformation associated recombination (TAR) cloning to maintain the genome as a yeast artificial chromosome (YAC). T7-RNA polymerase has been used to generate infectious RNA, which was then used to rescue viable virus. Based on this platform the authors have been able to engineer and resurrect chemically-synthetized clones of the recent epidemic SARS-CoV-2 in only a week after receipt of the synthetic DNA fragments.

Figure 2 Genome organization of the SARS-CoV-2 genome compared to other betacoronaviruses (from Chan 2020)



Origin of the virus

Phylogenetic and likelihood-mapping analyses of 12 genome sequences of the virus with known sampling date (24 December 2019 and 13 January 2020) and geographic location (primarily Wuhan city, Hubei Province, China) suggested a potentially large 'first generation' human-to-human virus transmission. Li, Zai et al. (J Med Virol 2020, see ***below***) estimated that SARS-CoV-2 likely originated in Wuhan on 9 November 2019 (95% credible interval: 25 September 2019 and 19 December 2019). Li, Wang et al. (J Med Vir 2020, see ***below***) confirmed the recent and rapid human-to-human transmission, with estimates of virus emergence ranging from 15 October to 10 November 2019 or 16 November to 22 December 2019 depending on the calculation method.

Paraskevis (Infect Genet Evol 2020, see ***below***) described the lack of a mosaic relationship of SARS-CoV-2 to the closely related sarbecoviruses, indicating the lack of a recombination event in the emergence of SARS-CoV-2. Hence, SARS-CoV-2 likely emerged from the accumulation of mutations responding to altered selective pressures or from the infidelity of RNA polymerase perpetuated as replication-neutral mutations (Fahmi Infect Genet Evol. 2020, see ***below***).

Patino-Galindo (manuscript on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.02.10.942748v1) suggested a two-hit scenario in the emergence of the SARS-CoV-2 virus whereby the virus ancestors in bats first acquired genetic characteristics of SARS by incorporation of a SARS-like RBD through recombination before 2009, and subsequently, those recombinants underwent convergent evolution.

Gu (on BioRxiv https://www.biorxiv.org/content/10.1101/2020.02.15.950568v2) reported that the amino acid usage pattern of SARS-CoV-2 was generally found similar to bat and human SARSr-CoVs. He also found greater synonymous codon usage distance between SARS-CoV-2 and its phylogenetic relatives on S and M genes, suggesting these two genes of SARS-CoV-2 are subjected to different evolutionary pressures.

Based on an analysis of the 4 structural genes, Kandeel (J MedVir 2020, see ***below***) further reported that SARS-CoV-2 prefers pyrimidine rich codons to purines. Most high-frequency codons were found to end with A or T, while the low

frequency and rare codons were ending with G or C. SARS-CoV-2 structural proteins showed 5-20 lower ENc values, compared with SARS, bat SARS and MERS-CoVs. This implies higher codon bias and higher gene expression efficiency of SARS-CoV-2 structural proteins. SARS-CoV-2 encoded the highest number of over biased and negatively biased codons. Pangolin β-CoV showed little differences with SARS-CoV-2 ENc values, compared with SARS, bat SARS and MERS CoV.

A manuscript by Zhang (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.25.20027953v1.full.pdf) provides a new hypothesis to explain the initial spread of the disease. Based on the analysis of 97 virus sequences, the authors were able to propose a classification of current SARS-CoV-2 isolates into two main types, with three sources of transmission, namely Type IA, Type IB, and Type II. Among them, Type IA corresponds to the earliest transmission source, which did not occur in the Huanan Market, indicating that the original transmission source was not from the Huanan Market. Type II comes from the Huanan Market. As most samples detected belong to Type II, it is speculated that a Type II virus is the major outbreak source. By analysing the three genomic sites distinguishing Type I and Type II strains, it was found that the synonymous changes at two of the three sites confer higher protein translational efficiencies to Type II strains. The authors speculate that this observation may be related to higher transmissibility of Type II strains.

Tang (preprint on National Science Review: https://academic.oup.com/nsr/advance-article/doi/10.1093/nsr/nwaa036/5775463?searchresult=1) presented new data on the origin and evolution of SARS-CoV-2. Although the authors found only 4% variability in genomic nucleotides between SARS-CoV-2 and the bat SARSr-CoV RaTG13, the difference at neutral sites was 17%, suggesting the divergence between the two viruses is much larger than previously estimated. The report also suggests that new variations in functional sites in the receptor-binding domain (RBD) of the spike seen in SARS-CoV-2 and viruses from pangolin SARSr-CoVs are likely caused by mutations and natural selection besides recombination. Based on the analyses of 103 SARS-CoV-2 genomes, the authors confirmed the publication by Zhang (see above) indicating that these viruses evolved into two major types. These 2 types were here designated L and S, with the L type (~70%) being more prevalent than the S type (~30%), and the S type representing the ancestral version. Of note, both types of virus were detected outside China.

Yi (Clin Inf Dis 2020, see ***below***) used a different approach to the analysis of 84 sequences in GISAID to provide evidence for genetic recombination underlying the evolution of the virus.

While comparing ORF1ab polyprotein with other βCoVs, Cárdenas-Conejo (J Med Vir 2020, see ***below***) found a 42 amino acid signature that is only present in SARS-CoV-2. Members from clade 2 of sarbecoviruses have traces of this signature. The amino acid signature located in the acidic-domain of papain-like protein of SARS-CoV2 and bat-SL-RatG13 guided the authors to suggest that SARS-CoV-2 probably emerged by genetic drift from bat-SL-CoV-RaTG13.

Xia (Mol Biol Evol 2020, see ***below***) observed that SARS-CoV-2 has the most extreme CpG deficiency in all known βCovs genomes. This suggests that SARS-CoV-2 may have evolved in a new host (or new host tissue) with high zinc finger antiviral protein expression. This observation allowed for a novel hypothesis for the origin of SARS-CoV-2. The ancestor of SARS-CoV-2 and BatCoV RaTG13 might have infected the intestine of a mammalian species (e.g., canids). Then the presumably strong selection against CpG in the viral RNA genome in canid intestine resulted in rapid evolution of the virus, with many CpG→UpG mutations leading to reduced genomic ICpG and GC%. The licking of anal regions in canids during mating and other circumstances facilitated viral transmission from the digestive system to the respiratory system. Finally, the reduced viral genomic ICpG allowed the virus to evade human zinc finger antiviral protein-mediated immune response and became a severe human pathogen.

Lau, Luk et al. (Em Inf Dis 2020, see ***below***) noted that despite the close relatedness of SARS-CoV-2 to bat and pangolin viruses, none of the existing SARS-related CoVs represents its immediate ancestor. Most of the genome region of SARS-CoV-2 is closest to SARSr-Ra-BatCoV-RaTG13 from an intermediate horseshoe bat in Yunnan, whereas its RBD is closest

to that of pangolin-SARSr-CoV/MP789/Guangdong/2019 from smuggled pangolins in Guangzhou. Potential recombination sites were identified around the RBD region, suggesting that SARS-CoV-2 might be a recombinant virus, with its genome backbone evolved from Yunnan bat virus-like SARS-related CoVs and its RBD region acquired from pangolin virus-like SARS-related CoVs.

In spite of these considerable research advancements, the origin of the virus remains ambiguous. Zhang (J Inf 2020, see ***below***) indicated that the source of the virus might be tracked in the following ways:

- Tracing back the viral emergence at the Huanan seafood market. It has been that the market has been closed for more than two months, but the government can list all merchants in the market and clarify which animals they sold, and what were the purchase channels of the animals. Thus, sampling the animals from their purchase channels appears feasible.
- Detection of the SARS-CoV-2-like virus in wild animals.
- Detection of serum antibody in clinical samples collected before December 2019 in Hubei Province, especially in Wuhan.

Multiple reasons to rule out a laboratory origin

While speculations, rumours and conspiracy theories that SARS-CoV-2 is of laboratory origin circulate in social media, several publications point to the lack of credible evidence to support the claim that SARS-CoV-2 originated from a laboratory-engineered CoV.

Liu (Emerg Micr Inf 2020, see ***below***), for instance, pointed to the fact that evolution is stepwise and accrues mutations gradually over time, whereas synthetic constructs would typically use a known backbone and introduce logical or targeted changes instead of the randomly occurring mutations that are present in naturally isolated viruses such as bat CoV RaTG13. However, the sequence data irrefutably show that SARS-CoV-2 is not derived from any previously used virus backbone. Hao (Emerg Microbes Inf 2020, see ***below***) ruled out a published claim that SARS-CoV-2 would have a unique inserted sequence (1378 bp) located in the middle of its S glycoprotein gene that had no match in other coronaviruses and that this unique sequence would be similar to some sequence in a common expression vector used in research laboratory.

Andersen (Nature Med 2020, see ***below***) added that while SARS-CoV-2 may bind human ACE2 with high affinity, computational analyses predict that the interaction is not ideal and that the RBD sequence is different from those shown in SARS-CoV to be optimal for receptor binding. Thus, the high-affinity binding of the SARS-CoV-2 S protein to human ACE2 is most likely the result of natural selection on a human or human-like ACE2 that permits another optimal binding solution to arise. This is strong evidence that SARS-CoV-2 is not the product of purposeful manipulation.

In theory, it is also possible that SARS-CoV-2 acquired RBD mutations during adaptation to passage in cell culture, as has been observed in studies of SARS-CoV (Andersen Nature Med 2020, see ***below***). The finding of SARS-CoV-like coronaviruses from pangolins with nearly identical RBDs, however, provides a much stronger explanation of how SARS-CoV-2 acquired these via recombination or mutation. The acquisition of both the polybasic cleavage site and predicted O-linked glycans also argues against culture-based scenarios. New polybasic cleavage sites have been observed only after prolonged passage of low-pathogenicity avian influenza virus *in vitro* or *in vivo*. Furthermore, a hypothetical generation of SARS-CoV-2 by cell culture or animal passage would have required prior isolation of a progenitor virus with very high genetic similarity, which has not been described. Subsequent generation of a polybasic cleavage site would have then required repeated passage in cell culture or animals with ACE2 receptors similar to those of humans, but such work has also not previously been described. Finally, the generation of the predicted O-linked glycans is also unlikely to have occurred due to cell-culture passage, as such features suggest the involvement of an immune system.

Sequence diversity among isolates

Virus isolates from five patients with severe pneumonia (hospitalized from December 18 to December 29, 2019 at Jin Yin-tan hospital in Wuhan) revealed 99.8-99.9% nucleotide identities (Ren Chinese Med J 2020, see ***below***). Zhou (Nature 2020, see ***below***) also reported more than 99.9% identity among isolates obtained from 7 patients at the beginning of the outbreak. Lu (Lancet 2020, see ***below***) reported 10 genome sequences of SARS-CoV-2 obtained from nine patients exhibiting more than 99.98% sequence identity. Ceraolo (J MedVir 2020, see ***below***) analyzed 56 genomes of SARS-CoV-2 and confirmed high sequence similarity (>99%). Of note, at least two hyper-variable genomic hotspots were detected, one of which is responsible for a Serine/Leucine variation in the viral ORF8-encoded protein. Another study conducted on 32 genomes of strains sampled from China, Thailand, and USA between 24 December 2019 and 23 January 2020 suggested increasing tree-like signals from 0 to 8.2%, 18.2%, and 25.4%) overtime, which may be indicative of increasing genetic diversity of SARS-CoV-2 in human hosts (Li, Wang et al. J Med Vir 2020, see ***below***).

Following the analysis of 54 gene sequences, Wen (J Infect 2020, see ***below***) noted the hyper-variable genomic hotspot to be established in the SARS-CoV-2 population at the nucleotide but not the amino acid level, suggesting that there have been no beneficial mutations acquired. Of note, nsp1, nsp3, and nsp15 of ORF1ab and gene S were found to carry significantly more mutations than other genes.

Subsequently, Wang (J Med Vir 2020, see ***below***) reported on the analysis of 95 full-length genomic sequences of SARS-CoV-2 strains from NCBI and GISAID databases. The homology among all viral strains was generally high, among them 99.99% (99.91%-100%) at the nucleotide level, 99.99% (99.79%-100%) at the amino acid level. Although overall variation in ORF regions is low, 13 variation sites in 1a, 1b, S, 3a, M, 8, and N regions were identified, among which positions nt28144 in ORF 8 and nt8782 in ORF 1a showed mutation rate of 30.53% (29/95) and 29.47% (28/95) respectively.

While the number of sequences deposited to GISAID increases rapidly (12 713 sequences by April 28 12:00 CET; see https://www.gisaid.org/epiflu-applications/next-betacov-app/), monitoring of the virus sequence diversity among the newest isolates continues.

The website of the China National Center for Bioinformation (https://bigd.big.ac.cn/ncov?lang=en), available in Chinese and English, constitutes another useful resource on SARS-CoV-2 sequences. Moreover, a new resource of interest, described by Cleemput (Bioinform 2020, see ***below***) is the Genome Detective Coronavirus Typing Tool, available at https://www.genomedetective.com/app/typingtool/cov, which can accurately identify SARS-CoV-2 sequences isolated in China and around the world.

Following metatranscriptome sequencing for the bronchoalveolar lavage fluid of SARS-CoV-2 patients, Shen (Clin Inf Dis 2020, see ***below***) presented data suggesting that SARS-CoV-2 evolves *in vivo* after infection. The median number of intra-host variants was 1-4 in SARS-CoV-2 infected patients, ranging between 0 and 51 in different samples. The distribution of variants on genes was similar to those observed in the population data (110 sequences). However, very few intra-host variants were observed in the population as polymorphism, implying either a bottleneck or purifying selection involved in the transmission of the virus, or a consequence of the limited diversity represented in the current polymorphism data.

The topic was also addressed by Bal (Clin Microb Inf 2020, see ***below***), who characterized whole genome sequences of SARS-CoV2 isolated from an asymptomatic patient, in 2 clinical samples collected 1 day apart. Comparison of these sequences suggests viral evolution with development of quasispecies. The study also identified a new deletion in nsp2 (Asp268Del). The analysis of 571 whole genome sequences identified this deletion in 37 other viruses collected in England (February) and in Netherlands (March), suggesting the spread of this deletion in Europe.

Benvenuto (J inf 2020, see ***below***) found in more recent isolates the presence of two mutations affecting NSP6 and ORF 10 adjacent regions. Amino acidic change stability analysis suggests both mutations could confer lower stability of the protein structures.

Sheikh (Infect Genet Evol. 2020, see ***below***) observed the 5′ terminal of the genome to be more variable and prone to mutations, as compared to the 3′ terminal. It appears that ORF1ab, S, ORF3a and E appeared as key drivers of diversity among strains with RBD of spike emerging as mutational hotspot. Phylogenetic analyses revealed at least five different clades circulating

Sequence homology of the S gene

The S gene of SARS-CoV-2 appears highly divergent to other CoVs, with less than 75% nucleotide sequence identity to all previously described SARS-CoVs, except a 93.1% nucleotide identity to RaTG13 (Zhou Nature 2020, see ***below***). The S genes of SARS-CoV-2 and RaTG13 S gene are longer than other SARS-CoVs. The major differences in SARS-CoV-2 are three short insertions in the N-terminal domain, and 4/5 key residues changes in the receptor-binding motif, in comparison with SARS-CoV.

At the level of amino acids, the S glycoprotein of SARS-CoV-2 was found to have 76.3% identity and 87.3% similarity with the S glycoprotein of SARS-CoV (Baruah J Med Virol 2020, see ***below***).

The S2 subunit of SARS-CoV-2 was found highly conserved, sharing 99% sequence identity with those of the two bat SARS-like CoVs (SL-CoV ZXC21 and ZC45) and human SARS-CoV (Chan Em Micr Inf 2020, see ***below***). This observation suggests that broad spectrum antiviral peptides against S2 may be considered as therapeutic candidates.

The S1 subunit of SARS-CoV-2 shares around 70% identity to that of the two bat SARS-like CoVs and human SARS-CoV. The core domain of the receptor binding domain (RBD) (excluding the external subdomain) is highly conserved, but the external subdomain of the SARS-CoV-2 RBD (which is responsible for the direct interaction with the host receptor) shares only 40% amino acid identity with other SARS-related coronaviruses. Of note, homology modelling in another study revealed that SARS-CoV-2 has a similar RBD structure to that of SARS-CoV, despite amino acid variation at some key residues (Lu Lancet 2020, see ***below)***. Moreover, several critical residues in SARS-CoV-2 RBD (particularly Gln493) provide favourable interactions with human ACE2, consistent with SARS-CoV-2's capacity for human cell infection (Wan J Virol 2020, see ***below***). Several other critical residues in SARS-CoV-2 RBD (particularly Asn501) are compatible with, but not ideal for, binding human ACE2.

Structure of S and interactions with the ACE2 receptor

Jaimes (manuscript on ArXiv: https://arxiv.org/ftp/arxiv/papers/2002/2002.06196.pdf) performed structural modelling of the SARS-CoV-2 S glycoprotein. The data provided support for a similar receptor utilization between SARS-CoV-2 and SARS-CoV, despite a relatively low amino acid similarity in the receptor binding module. Compared to SARS-CoV, an extended structural loop containing basic amino acids was identified at the interface of the receptor binding (S1) and fusion (S2) domains, which was predicted to be proteolytically-sensitive. Jaimes suggested this loop confers fusion activation and entry properties more in line with other coronaviruses.

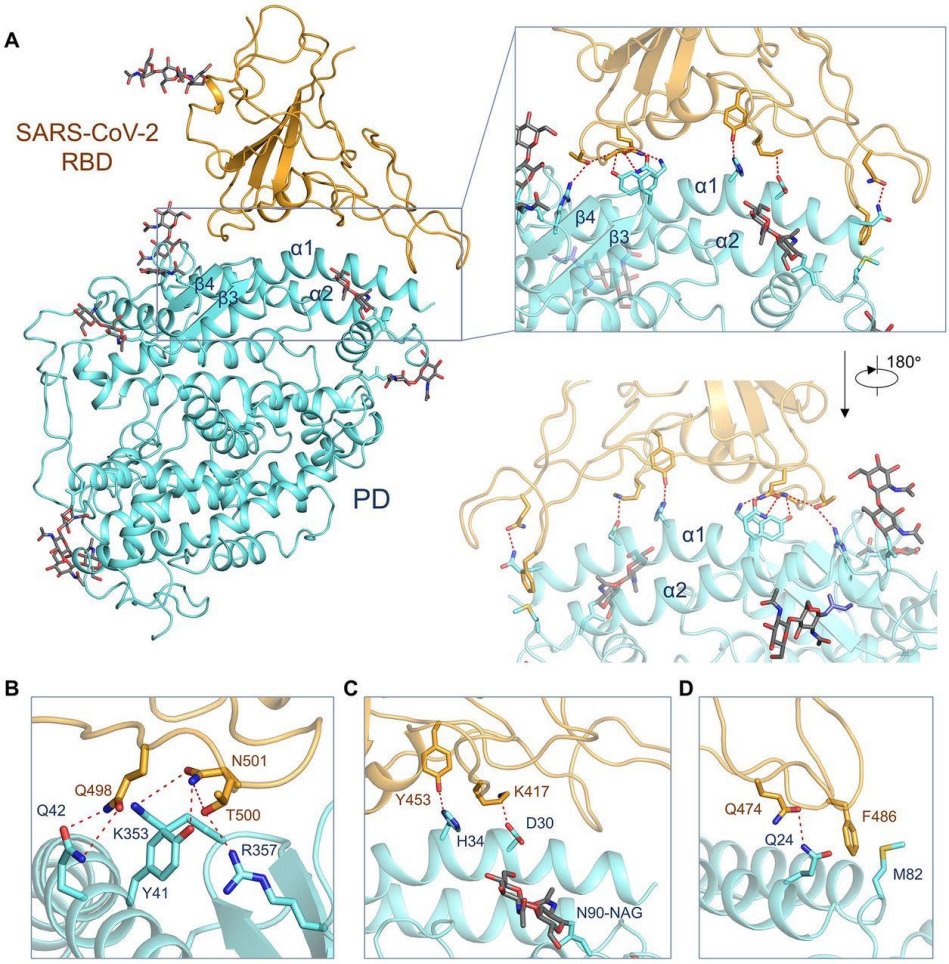
Wrapp (Science 2020, see ***below***) disclosed the 3.5 Å-resolution cryo-EM structure of the SARS-CoV-2 S trimer in the prefusion conformation. The predominant state of the trimer has one of the three receptor-binding domains (RBDs) rotated up in a receptor-accessible conformation. He also showed biophysical and structural evidence that SARS-CoV-2 S binds ACE2 with higher affinity than SARS-CoV S. Additionally he tested several published SARS-CoV RBD-specific monoclonal antibodies and found that no appreciable binding to SARS-CoV-2 S, confirming previous conclusions from sequence analyses that antibody cross-reactivity may be limited between the two virus RBDs.

Yan (Science 2020, see ***below***) presented the cryo-EM structures of full-length human ACE2, in the presence of a neutral amino acid transporter B0AT1, with or without the receptor binding domain (RBD) of the surface spike

glycoprotein (S protein) of SARS-CoV-2, both at an overall resolution of 2.9 Å, with a local resolution of 3.5 Å at the ACE2-RBD interface. The ACE2-B0AT1 complex is assembled as a dimer of heterodimers, with the Collectrin-like domain (CLD) of ACE2 mediating homo-dimerization (see Figure 3). The RBD is recognized by the extracellular peptidase domain (PD) of ACE2 mainly through polar residues.

The structural basis of ACE2 receptor recognition by SARS-CoV-2 was further investigated by Shang (Nature 2020, see ***below***) and Lan (Nature 2020, see ***below***). Compared with the SARS-CoV RBD, a human ACE2-binding ridge in SARS-CoV-2 RBD was found to take a more compact conformation; moreover, several residue changes in SARS-CoV-2 RBD stabilize two virus-binding hotspots at the RBD/hACE2 interface. These structural features of SARS-CoV-2 RBD enhance its hACE2-binding affinity. The same observation was made by Wang (Cell 2020, see ***below***).

Figure 3 Interactions between SARS-CoV-2-RBD and ACE2 (from Yan Science 2020).



Letko (Nature Microb 2020, see ***below***) confirmed previous observations in terms of receptor usage of the virus, and suggested that SARS-CoV-2 is capable of using human ACE2 efficiently, which may help to explain human-to-human transmissibility. The experiments were based on the use of pseudotypes and investigated the mechanism of entry of a whole set of lineage B βCoVs.

Ibrahim (J Inf 2020, see ***below***) developed predictions of the COVID-19 S binding site to the cell-surface receptor (Glucose Regulated Protein 78 (GRP78)). The study revealed that binding is more favourable between regions III (C391-C525) and IV (C480-C488) of the spike protein model and GRP78. Region IV was found the main driving force for GRP78 binding with the predicted binding affinity of -9.8 kcal/mol. These nine residues could be used to develop therapeutics specific against COVID-19.

Of note, Xia (Cell Mol Immunol 2020, see ***below***) published a report on the fusion mechanism of SARS-CoV-2 and fusion inhibitors targeting HR1 domain in S protein.

Other SARS-CoV-2 genes and proteins

A manuscript by Alam (https://www.biorxiv.org/content/10.1101/2020.02.17.952895v1.full.pdf) shows the conservation of the **E gene**, differing between SARS and SARS-Cov2 with a difference of single amino acid substitution and a single amino acid insertion present in SARS but absent from SARS-CoV-2. The authors recommend diagnosis based on this protein.

The **RNA-dependent RNA polymerase** (RdRp, also named **nsp12**) is the central component of coronaviral replication/transcription machinery. Gao (Science 2020, see ***below***) reported the cryo-EM structure of the full-length viral nsp12 in complex with cofactors nsp7 and nsp8 at 2.9-Å resolution. In addition to the conserved architecture of the polymerase core of the viral polymerase family, nsp12 possesses a newly identified β-hairpin domain at its N terminus. The structure provides a basis for the design of new antiviral therapeutics targeting viral RdRp.

Immunity to SARS-CoV-2 infection

While information pertaining to immune responses to SARS-CoV-2 remains scarce, data are available to characterize both innate and adaptive immune responses to SARS-CoV and MERS-CoV (see for instance Li J Med Virol 2020 ***below***). Such knowledge can be expected to facilitate vaccine development as well as specific immunotherapy against COVID-19.

Epitope predictions

Immune-informatics approaches targeting identification of T and B cell epitopes of SARS-CoV-2 have been described by several authors.

Baruah (J Med Virol 2020, see ***below***) for instance, predicted five CTL epitopes, three sequential B cell epitopes and five discontinuous B cell epitopes in the S glycoprotein, as illustrated by Table 2 below. Simulations suggested that the CTL epitopes bind MHC class I peptide-binding grooves via multiple contacts, with continuous hydrogen bonds and salt bridge anchors, supporting their potential in generating immune responses. Of note, the study found only one overlapping CTL epitope between MERS-CoV and SARS-CoV-2 with one gap and one mismatch (Y-LQPRTFLL/YKLQPLTFLL), and no comparable epitopes with SARS-CoV.

Kumar (manuscript on Preprints: https://www.preprints.org/manuscript/202002.0071/v1) predicted 8 B cell epitopes in the S protein based on the antigenicity score by using Vaxigen 2.0 (Table **3**), some of which displayed overlap with those predicted by Baruah.

Table 2 Epitopes predicted in SARS-CoV-2 S glycoprotein (from Baruah J Med Virol 2020)

CTL epitopes	Epitope	Epitope score ANN/SVM	Antigenicity (score)	HLA (%Rank)
	YLQPRTFLL	0.83/0.64	Y (0.45)	HLA-A*02:01 (0.01)
	GVYFASTEK	0.58/0.98	Y (0.71)	HLA-A*03:01 (0.00)
	EPVLKGVKL	0.73/0.61	Y (1.23)	HLA-B*07:02 (0.28)
	VVNQNAQAL	0.77/0.78	Y(0.47)	HLA-B*07:02 (0.78)
	WTAGAAAYY	0.82/0.54	Y (0.63)	HLA-B*15:01 (0.37)
B sequential epitopes	Epitope	Epitope probability	Antigenicity (score)	IFN-γ epitope (score)
	CVNLTTRTQLPPAYTN	0.74	Y (1.38)	N (-0.92)
	NVTWFHAIHVSGTNGT	0.55	Y (0.84)	N (-0.30)
	SFSTFKCYGVSPTKLNDL	0.69	Y (1.06)	N (-0.16)
B discontinuous epitopes	Number	Epitope:Position		Score
	1	H1271, Y1272, T1273		0.998
	2	E1258, D1259, D1260, S1261, E1262, P1263, V1264, L1265, K1266, G1267, V1268, K1269, L1270		0.985
	3	G838, D839, C840, L841, G842, D843, I844, A845, A846, R847, D848, L849, I850, C851, A852, Q853, K854, F855		0.866
	4	Y1215, I1216, L1218, G1219, F1220, I1221, A1222, G1223, L1224, I1225, A1226, I1227, V1228, M1229, V1230, T1231, I1232, M1233, L1234, C1235, C1236, M1237, T1238, S1239, C1240, C1241, S1242, C1243, L1244, K1245, G1246, C1247, C1248, S1249, C1250, G1251, S1252, C1253, C1254, K1255, F1256, D1257		0.832
	5	M1, F2, V3, F4, L5, V6, L7, L8, P9, L10, V11, S12, S13, Q14, C15, V16, N17, L18		0.786

Table 3 B-cell epitopes present on surface predicted by Kumar

Number	Epitope sequence	Vaxigen score
1	VLLPLVSSQCVNLTTRTQLPPAYTN	1.0555
2	RSSVLHSTQD	0.5404
3	VTWFHAIHVSGTNGTKRFDN	0.5485
4	VYFASTEKSNII	0.7795
5	GTTLDSKTQSLLIVNNATNVVIKVC	0.4494
6	YYHKNNKSWMESEFRVYSSANNCTFEYVSQP FLM	0.2569
7	IYSKHTPIN	0.9013
8	DLPQGFSALEPLVDLPIGINITRFQTLLALH RSYLTPGDSSSGWTAGAAAYYLLKYNENGTIT DAVDCALDPLSETKCTLKSFTVEKGIYQTSN FRVQPTESVRFPNITNLCPFGE	0.6329

Predictions of CD4 and CD8 epitopes were also reported by various teams, reaching quite different conclusions (Kumar on Preprints : https://www.preprints.org/manuscript/202002.0071/v1; or Bojin on Preprints : https://www.preprints.org/manuscript/202002.0102/v1). The approach selected by Ahmed (Vir 2020, see ***below***) focused on one side on S and N epitopes conserved across isolates and T cell epitopes offering broad coverage.

Fast (on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.02.19.955484v1) reported the use of various computational tools from structural biology and machine learning to identify SARS-CoV-2 epitopes based on viral protein antigen presentation and antibody binding properties. The study identified two potential neutralizing B-cell

epitopes near the spike protein RBD (positions 440-460 and 494-506) and a whole set of potential MHC I and II epitopes (see Table 4).

Table 4. Top potential T cell epitopes for key 2019-nCoV proteins*

Gene	Sequence	Position	MHC-I Cov.		MHC-II Cov.		Antibody
S	SYGFQPTNGVGYQPY	494	Yes	52%	Yes	100%	Yes
	SQSIIAYTMSLGAEN	689	Yes	74%	Yes	100%	No
	IPTNFTISVTTEILP	714	Yes	70%	Yes	100%	No
	AAAYYVGYLQPRTFL	262	Yes	65%	Yes	100%	No
	APHGVVFLHVTYVPA	1056	Yes	65%	Yes	100%	?
ORF1ab	DGEVITFDNLKTLLS	1547	Yes	83%	Yes	100%	No
	EVRTIKVFTTVDNIN	1564	Yes	78%	Yes	100%	No
	IINLVQMAPISAMVR	2368	Yes	78%	Yes	100%	No
	NPTTFHLDGEVITFD	1540	Yes	74%	Yes	100%	No
	VAAIFYLITPVHVMS	2783	Yes	74%	Yes	100%	No
M	IASFRLFARTRSMWS	97	Yes	65%	Yes	100%	?
N	ATKAYNVTQAFGRRG	264	Yes	74%	Yes	100%	?
E	VKPSFYVYSRVKNLN	52	Yes	74%	Yes	100%	?

** Epitopes were ranked based on their likely coverage of presentation by MHC-I and MHC-II alleles. S protein 494-508 is highly ranked based on MHC presentation and is also one of the predicted top B-cell epitopes, localized near the S protein receptor binding domain. MHC-I coverage is calculated by the 9mer with the highest MHC-I coverage for each epitope (highlighted in orange). All candidates are likely to be presented by both MHC-I and MHC-II. A question mark (?) under the antibody column indicates that one or more SARS homolog of this peptide is a known B-cell epitope.*

Additional epitope predictions were also reported by Bhattacharya (J Med Virol 2020, see ***below***).

Grifoni (Cell Host & Micr 2020, see ***below***) identified multiple specific regions in SARS-CoV-2 that have high homology to the SARS-CoV virus. Parallel bioinformatic predictions identified a priori potential B and T cell epitopes for SARS-CoV-2. The authors suggested that independent identification of the same regions using two approaches reflects the high probability that these regions are promising targets for immune recognition of SARS-CoV-2. In this study, 10 B cell epitopes were identified with high sequence similarity between SARS-CoV and SARS-CoV-2. Five of these epitopes were found in the S protein, two in the membrane protein, and three in the nucleocapsid (N) protein. T cell epitopes were mostly found in the S protein and N protein.

Observations in COVID-19 patients

Thevarajan (Nat Med, see ***below***) reported the kinetics of the immune response in relation to clinical and virological features of a patient with mild-to-moderate COVID-19 requiring hospitalisation. Increased antibody-secreting cells, follicular T-helper cells, activated CD4+ and CD8+ T-cells and IgM/IgG SARS-CoV-2-binding antibodies (immunofluorescence assay using SARS-CoV-2-infected Vero cells) were detected in blood, prior to symptomatic recovery. These immunological changes persisted for at least 7 days following full resolution of symptoms. Of note, the authors detected reduced frequencies of CD16+ CD14+ monocytes in peripheral blood at day 7-9, which might indicate efflux of CD16+CD14+ monocytes from blood to the site of infection. Low levels of activated HLA-DR+ CD3-CD56+ NK cells were found in both the COVID-19 patient and healthy controls.

Antibody response

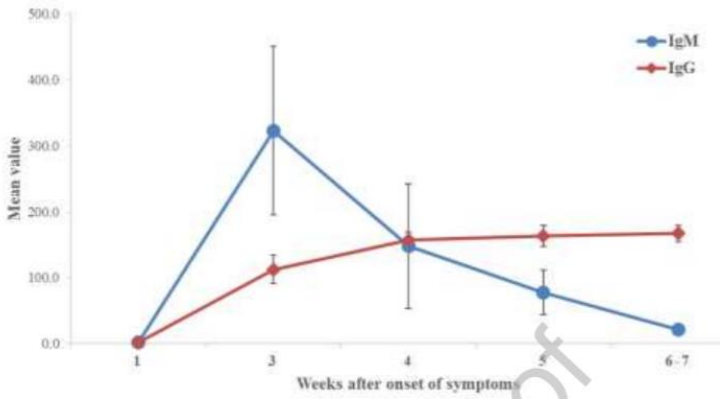
By using an ELISA based assay using the recombinant viral nucleocapsid, Guo (Clin Inf Dis 2020, see ***below***) examined the host humoral response against SARS-CoV-2 including IgA, IgM and IgG responses. A total of 208 plasma samples were collected from 82 confirmed and 58 probable cases. The diagnostic value of IgM was evaluated in this cohort. The median duration of IgM and IgA antibody detection were 5 days (IQR 3-6), while IgG was detected on 14 days (IQR 10-18) after symptom onset, with a positive rate of 85.4%, 92.7% and 77.9% respectively. In confirmed and probable cases, the positive rates of IgM antibodies were 75.6% and 93.1%, respectively. The detection efficiency by IgM ELISA

was higher than that of qPCR method after 5.5 days of symptom onset. The positive detection rate was significantly increased (98.6%) when combined IgM ELISA assay with PCR for each patient compare with a single qPCR test (51.9%).

Immunology testing was also performed in 16 patients in Hong Kong using serum samples collected 14 days or longer after symptom onset (To Lancet Inf Dis 2020, see ***below***). The following rates of seropositivity were reported: 94% for anti-N IgG (n=15), 88% for anti-N IgM (n=14), 100% for anti-RBD IgG (n=16), and 94% for anti-RBD IgM (n=15). Anti-SARS-CoV-2-N or anti-SARS-CoV-2-RBD IgG levels correlated with virus neutralization titre (R^2>0·9).

Xiao (J Inf 2020: https://www.journalofinfection.com/article/S0163-4453(20)30138-9/pdf) presented the kinetics of IgM and IgG responses in 34 patients (Figure 4).

Figure 4 Timeline of IgM and IgG antibodies level to SARS-CoV-2 from onset of symptoms (from Xiao J Inf 2020)



Wu (non-peer-reviewed manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.03.30.20047365v1) characterized antibody responses in a large cohort of 175 COVID-19 recovered patients with mild symptoms. The levels and the time course of SARS-CoV-2-specific neutralizing antibodies (NAbs) (pseudotyped-lentiviral-vector-based neutralization assay) and the S-binding antibodies (ELISA using RBD, S1, and S2 proteins) were monitored in parallel. SARS-CoV-2-specific NAbs were detected in patients from day 10-15 after the onset of the disease and remained thereafter. No cross-reactivity with SARS-CoV was observed. The NAb titers correlated with the S-binding antibodies targeting S1, RBD, and S2 regions. Elderly and middle-age patients had significantly higher plasma NAb titers (P<0.0001) and spike-binding antibodies (P=0.0003) than young patients. The NAb titers were positively correlated with plasma CRP levels but negatively correlated with the lymphocyte counts of patients at the time of admission, indicating an association between humoral response and cellular immune response.

Catalan-Dibene (Nature Reviews Immunology 2020, see ***below***) described a preprint by Ju, who demonstrated the existence of virus-specific memory B cells recognizing the RBD of SARS-CoV-2 S protein in infected patients. They observed crossreactivity of antibodies from these patients against S proteins, but not against the RBD, of SARS-CoV-1 and MERS-CoV. Through single-cell sorting and BCR sequencing, they generated 206 SARS-CoV-2 RBD-specific monoclonal antibodies. Antibodies were from diverse families of immunoglobulin genes, without any apparent enrichment for specific families. Two clones showed 98–99% blocking of viral entry, which correlated with high competing capacity against ACE2 receptor.

Cellular responses

Flow cytometry analyses

A study of the dynamic changes of lymphocyte subsets and cytokines profiles of 40 COVID-19 patients has been reported by Liu (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.16.20023671v1). Significant decreases in the counts of T cells, especially CD8 + T cells, were observed as well as increases in IL-6, IL-10, IL-2 and

IFN-γ levels in the peripheral blood in the severe cases compared to those in the mild cases. T cell counts and cytokine levels in severe COVID-19 patients who survived the disease gradually recovered at later time points to levels that were comparable to those of the mild cases.

Wang (J Inf Dis 2020, see ***below***) measured peripheral blood lymphocyte subsets in 60 hospitalized COVID-19 patients before and after treatment. Total lymphocytes, CD4+ T cells, CD8+ T cells, B cells and NK cells decreased in COVID-19 patients, and severe cases had a lower level than mild cases. The subsets (especially CD8+ T cells and CD4+/CD8+ ratio) showed a significant association with the inflammatory status. After treatment, 37 patients (67%) reached clinical response, with an increase of CD8+ T cells and B cells. In multivariate analysis, post-treatment decrease of CD8+ T cells and B cells and increase of CD4+/CD8+ ratio were indicated as independent predictors for poor efficacy.

A manuscript by Liao (not peer-reviewed, on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.23.20026690v1) characterized the lung immune microenvironment with the bronchoalveolar lavage fluid (BALF) from 3 severe and 3 mild COVID-19 patients. The data show that monocyte-derived FCN1+ macrophages, but not FABP4+ alveolar macrophages that represent a predominant macrophage subset in BALF from patients with mild diseases, overwhelm in the severely damaged lungs from patients with acute respiratory distress syndrome (ARDS). These cells are highly inflammatory and enormous chemokine producers implicated in cytokine storm. Furthermore, the formation of tissue resident, highly expanded clonal CD8+ T cells in the lung microenvironment of mild symptom patients suggests a robust adaptive immune response.

Zheng, Gao et al. (Cell Mol Imm 2020, see ***below***) published data indicating that SARS-CoV-2 infection may break down antiviral immunity at an early stage. The authors showed that the total number of NK and CD8+ T cells was decreased markedly in patients with SARS-CoV-2 infection, and further showed that NKG2A expression is upregulated on NK cells and CTLs in patients, with a reduced ability to produce CD107a, IFN-γ, IL-2, granzyme B, and TNF-α. Also, the percentage of NKG2A+ cytotoxic lymphocytes was found decreased in recovered patients infected with SARS-CoV-2, which strongly suggests that **NKG2A expression** may be correlated with functional exhaustion of cytotoxic lymphocytes and disease progression in the early stage of COVID-19.

Zheng, Zhang et al. (Cell Mol Imm 2020, see ***below***) provided a detailed analysis of the immunological characteristics of peripheral blood leukocytes from 16 patients, incl. 10 mild cases and 6 severe cases. The levels of **IFN-γ and TNF-α in CD4+ T cells** were lower in the severe group than in the mild group, whereas the levels of **granzyme B and perforin in CD8+ T cells** were higher in the severe group than in the mild group. The activation molecules showed no differences in CD4+ T cells, whereas the levels of **HLA-DR and TIGIT in CD8+ T cells** were higher in the severe group than in the mild group. These data indicate that COVID-19, similar to some chronic infections, damages the function of CD4+ T cells and promotes excessive activation and possibly subsequent exhaustion of CD8+ T cells. Compared with the healthy control and mild group, the frequency of multi-functional CD4+ T cells (positive for at least two cytokines) decreased significantly in the severe group. In CD8+ T cells, the frequency of the non-exhausted (PD-1−CTLA-4−TIGIT−) subset in the severe group was found significantly lower than that in the other two groups, an observation confirming the report by Zheng, Gao et al. mentioned above.

Transcriptional changes

Ong (Cell Host & Microbe 2020: https://marlin-prod.literatumonline.com/pb-assets/journals/research/cell-host-microbe/chom_2283_s5.pdf) profiled the transcriptional changes in a panel of immune genes in 3 COVID-19 patients and 10 healthy volunteers. Attenuated cytokine expression associated with mild infection was suggested to possibly delay T cell immunity against SARS-CoV-2, which would prolong infection, leading to the possibility that afebrile and undifferentiated COVID-19 cases may drive virus spread in the community.

Blanco-Melo (manuscript on bioRxiv: https://www.biorxiv.org/content/10.1101/2020.03.24.004655v1) compared the transcriptional response of SARS-CoV-2 to that of seasonal influenza A virus (IAV) and respiratory syncytial virus in lung epithelium and transformed lung alveolar cells. The authors observed that the transcriptional response to SARS-CoV-2 infection shows a significant lack of type I and III interferon (IFN-I and IFN-III) expression as compared to IAV and RSV. Previous reports also demonstrated that coronaviruses hold mechanisms to evade host innate immune responses, in particular type I IFN signalling.

The data can be analysed in light of a recent publication by Hackbart (PNAS 2020, see ***below***), who demonstrated that a coronavirus endoribonuclease (EndoU) delays the activation of the host sensor system, by a mechanism where EndoU cleaves the 5-polyuridines from negative-sense viral RNA, which would otherwise be recognized by the cytosolic RNA sensor MDA5. Taken together, these findings suggest that SARS-CoV-2 can evade or delay antiviral immunity, ultimately leading to a dysregulated immune response and increased immunopathogenesis.

Immunity to other coronaviruses and cross-reactivity

Data pertaining to immunity against other coronaviruses could be very relevant to the understanding of immune responses to (and pathogenesis of) SARS-CoV-2. For instance, Wang (Virol Sin 2018, see ***below***) found antibodies against bat SARS-related coronavirus in people living near caves inhabited by bats in China. A recent report also described serology testing against common human CoV strains in a prospective study of 200 subjects evaluated for respiratory infections in the U.S. (Gorse J Med Vir 2020, see ***below***). Interestingly, a publication by Chan (J Clin Virol 2009, see ***below***) presented the seroprevalence of HCoV HKU1 according to age, showing steadily increasing seroprevalence in childhood and early adulthood, from 0% in the < 10 years age group to a plateau of 21.6% in the 31-40 years age group in Hong Kong. To what extent such immunity may impact immune responses to SARS-CoV-2 remains to be defined.

Cross-reactivity of antibodies

Based on structure analyses, Tian (Em Inf Dis 2020, see ***below***) predicted potent binding of COVID-19 S protein by SARS-specific human monoclonal antibody CR3022. Yuan (Science 2020, see ***below***) determined the crystal structure of CR3022 in complex with the receptor-binding domain (RBD) of the SARS-CoV-2 S protein. CR3022 was found to target a highly conserved epitope, distal from the receptor-binding site, that enables cross-reactive binding between SARS-CoV-2 and SARS-CoV. However, *in vitro* experiments remain to be done to confirm neutralization.

Using MLV-based pseudotypes neutralization assays, Walls (Cell 2020, see ***below***) investigated the ability of plasma from four mice immunized with a stabilized SARS-CoV S to inhibit SARS-CoV-2 S- and SARS-CoV S-mediated entry into target cells. All sera tested completely inhibited transduction of SARS-CoV S-MLV and reduced SARS-CoV-2 S-MLV transduction to ~10% of control in Vero E6 cells. The elicitation of a heterotypic response blocking SARS-CoV-2 S-mediated entry into host cells concurred with the sequence and structural conservation of SARS-CoV-2 S and SARS-CoV S along with their comparable glycans shields and suggested that immunity against one virus of the sarbecovirus subgenus can potentially provide protection against related viruses.

Ou (Nature Comm 2020, see ***below***) also investigated antibody cross-reactivity between SARS-CoV-2 S and SARS-COV S. Polyclonal anti-SARS S1 antibodies T62 inhibited entry of SARS-CoV S- but not SARS-CoV-2 S-pseudovirions. Further studies using recovered SARS and COVID-19 patients' sera showed limited cross-neutralization.

Immune evasion mechanisms

RNAi

As explained by Mu (Sci China Life Sci. 2020, see ***below***), viral infection and replication generates virus-derived dsRNA (vi-dsRNA), which could be recognized and cleaved by the host endoribonuclease Dicer into virus-derived siRNAs (vsiRNAs). These vsiRNAs are integrated into the Argonaute protein within the RNA-induced silencing complex (RISC)

to direct the destruction of cognate viral RNAs in infected cells in a sequence-specific manner. As a countermeasure, viruses encode viral suppressors of RNAi (VSRs) to antagonize the RNAi pathway at different steps. Previous study has reported that SARS-CoV nucleocapsid (N) protein displayed a VSR activity in mammalian cells via a cellular reversal-of-silencing assay. Mu showed that SARS-CoV-2 can act as a VSR in cells in both initiation and effector steps of RNAi, thereby probably representing a key immune evasion factor of SARS-CoV-2 and contributing to the pathogenicity of the virus.

Clinical disease

Initial observations in Wuhan

In December, 2019, a series of pneumonia cases of unknown cause emerged in Wuhan, Hubei, China, with clinical presentations greatly resembling viral pneumonia (http://www.who.int/csr/don/12-january-2020-novel-coronavirus-china/en/). By Jan 2, 2020, 41 admitted hospital patients had been identified as having laboratory-confirmed COVID-19 (Huang Lancet 2020, see ***below***). Most of the infected patients were men (30 [73%] of 41); less than half had underlying diseases (13 [32%]), including diabetes (eight [20%]), hypertension (six [15%]), and cardiovascular disease (six [15%]). Median age was 49.0 years (IQR 41.0-58.0). 27 (66%) of 41 patients had been exposed to Huanan seafood market. One family cluster was found. Common symptoms at onset of illness were fever (40 [98%] of 41 patients), cough (31 [76%]), and myalgia or fatigue (18 [44%]); less common symptoms were sputum production (11 [28%] of 39), headache (three [8%] of 38), haemoptysis (two [5%] of 39), and diarrhoea (one [3%] of 38). Dyspnoea developed in 22 (55%) of 40 patients (median time from illness onset to dyspnoea 8·0 days [IQR 5.0-13.0]). 26 (63%) of 41 patients had lymphopenia. All 41 patients had pneumonia with abnormal findings on chest CT. Complications included acute respiratory distress syndrome (12 [29%]), RNAaemia (six [15%]), acute cardiac injury (five [12%]) and secondary infection (four [10%]). 13 (32%) patients were admitted to an ICU and six (15%) died. Compared with non-ICU patients, ICU patients had higher plasma levels of IL2, IL7, IL10, GSCF, IP10, MCP1, MIP1A, and TNFα.

Incubation period

Among the first 425 patients with confirmed COVID-19-pneumonia, the mean incubation period was 5.2 days (95% confidence interval, 4.1 to 7.0), with the 95th percentile of the distribution at 12.5 days (Li New Engl J Med 2020, see ***below***). This observation was confirmed by other datasets as illustrated in Table 5 below.

Table 5 Incubation period as reported by different studies

	Mean incubation period and 95% confidence interval	Other information
Li NewEngl J Med 2020	5.2 days (95% CI, 4.1 to 7.0)	95th percentile of the distribution at 12.5 days
Liu (https://www.biorxiv.org/content/10.1101/2020.01.25.919787v1.full)	4.8 days (±2.6)	ranging from 2 to 11 days
Wang (https://www.medrxiv.org/content/10.1101/2020.02.21.20026112v2.full.pdf)	7.4 days	median 7 days (no more than 14 days for 92% patients)
Backer (https://www.medrxiv.org/content/10.1101/2020.01.27.20018986v2)	6.4 days (95% CI, 5.6 - 7.7)	ranging from 2.1 to 11.1 days (2.5th to 97.5th percentile)
Guan (https://www.medrxiv.org/content/10.1101/2020.02.06.20020974v1.full.pdf)		median of 3 days; ranging from 0 to 24 days
Xu BMJ 2020		median 4 days (interquartile range 3-5 days)
Jia Disaster Med Public Health Prep 2020	6.28 days	
Leung Infect Control Hosp Epidemiol 2020	1.8 days (95% CI, 1.0 to 2.7)	For travellers to Hubei
Leung Infect Control Hosp Epidemiol 2020	7.2 days (95% CI, 6.1 to 8.4)	For non-travellers

Lauer (Ann Intern Med 2020, see ***below***) assessed the incubation period using a compilation of 181 published cases with identifiable exposure and symptom onset windows. A median incubation period of 5.1 days (95% CI, 4.5 to 5.8 days) was found, with 97.5% of those who develop symptoms doing so within 11.5 days (CI, 8.2 to 15.6 days) of infection. These estimates imply that, under conservative assumptions, 101 out of every 10,000 cases will develop

symptoms after 14 days of active monitoring or quarantine. Whether this risk is acceptable will depend on the underlying risk of infection and consequences of missed cases.

Similar results were obtained by Linton (J Clin Med 2020 see ***below***), who found the incubation period to falls within the range of 2–14 days with 95% confidence and to have a mean of around 5 days. Based on the 95th percentile estimate of the incubation period, she recommended that the length of quarantine should be at least 14 days.

A systematic review of COVID-19 epidemiology by Park (J Clin Med 2020, see ***below***), which included 41 studies, indicated an estimated incubation period of 4-6 days.

Interestingly, based on reports collected in China, Han (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.24.20027474v1) found that the incubation periods of groups of individuals with age>=40 years and age<40 years demonstrated a statistically significant difference. The former group had a longer incubation period and a larger variance than the latter. Cai (Clin Inf Dis 2020, see ***below***) reported an incubation period in children of about two days usually, with a range of 2-10 days.

Description of clinical disease

Shi (Cell Death Diff 2020, see ***below***) described SARS-CoV-2 infection as a 3-stage process: stage I, an asymptomatic incubation period with or without detectable virus; stage II, non-severe symptomatic period with the presence of virus; stage III, severe respiratory symptomatic stage with high viral load.

Clinical disease in China

Individual reports

A large number of reports provide descriptions of the clinical signs associated with COVID-19 in Wuhan and other cities in China. The disease ranges from mild infection to severe acute respiratory infection. Table 6 illustrates the signs and symptoms detected in a selection of early reports describing the disease as observed in hospitalized patients.

Table 6 Clinical presentation in different cohorts of patients with COVID-19 pneumonia (frequency of reported symptoms)

	Chen Lancet 2020 (n=99*)	Song Radiol 2020 (n=51)	Chang JAMA 2020 (n=13)	Guan NEJM 2020 (n=1099**)	Wang JAMA 2020 (n=138)
fever	83%	96%	92.3%	88.7%	98.6%
cough	82%	47%	46.3%	67.8%	59.4%
shortness of breath (dyspnoea)	31%			18.7%	31.2%
muscle ache (myalgia)	11%	31%	23.1%	14.9%	34.8%
fatigue				38.1%	69.6%
confusion	9%				
headache	8%	16%	23.1%	13.6%	
sore throat	5%			13.9%	
rhinorrhoea	4%				
chest pain	2%				
diarrhoea	2%	10%		3.8%	10.1%
nausea and vomiting	1%			5%	10.1%
acute respiratory distress syndrome	17%			3.4%	

** Among the 99 patients, 76% patients received antiviral treatment, including oseltamivir (75 mg every 12 h, orally), ganciclovir (0.25 g every 12 h, intravenously), and lopinavir and ritonavir tablets (500 mg twice daily, orally). The duration of antiviral treatment was 3-14 days (median 3 days)*

*** patients with laboratory-confirmed COVID-19 acute respiratory disease from 552 hospitals in 31 provinces/provincial municipalities through January 29th, 2020; see https://www.medrxiv.org/content/10.1101/2020.02.06.20020974v1*

Additional data were also made available in the reports listed below (non-exhaustive):

- Zhang (Virol Sin 2020, see ***below***) described 2 cases of COVID-19 in Wuhan
- Huang (Trav Med Inf Dis 2020, see ***below***) described 34 cases in Wuhan

- Chen (on MedRxiV: https://www.medrxiv.org/content/10.1101/2020.02.16.20023903v1) described 21 patients with COVID-19
- Li (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.11.20022053v1.full.pdf) described 17 patients outside Wuhan
- Cai (on MedRXiv : https://www.medrxiv.org/content/10.1101/2020.02.17.20024018v1) described 298 confirmed cases in the Third People's Hospital of Shenzhen, from January 11, 2020 to February 6, 2020
- Zhang (Allergy 2020, see ***below***) described 140 patients in Wuhan, aged 25 to 87 years
- Liu (Chin Med J 2020, see ***below***) described 78 patients in Wuhan
- Yang (Lancet 2020, see ***below***) described 52 critically ill patients
- Liu (on MedRxiv https://www.medrxiv.org/content/10.1101/2020.02.17.20024166v3) described 109 patients, including 53 severe disease cases.
- Xu (BMJ 2020, see ***below***) described 62 hospitalized patients with confirmed infection in seven hospitals in Zhejiang province.
- Wu (Clin Inf Dis 2020, see ***below***) described 80 patients in Jiangsu Province.
- Yang (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.28.20028068v1) analysed 55 hospitalized cases in Beijing.
- Zhou (Lancet 2020, see ***below***) provided details on 191 patients with laboratory-confirmed disease in Wuhan.
- Qian (QJM 2020, see ***below***) described 91 hospitalized patients with COVID-19 in Zhejiang.

Metaanalyses

A metaanalysis by Sun (J Med Vir 2020, see below) covered ten of these studies[1], including a total number of 50 466 patients. It confirmed that fever and cough are the most common symptoms in patients with SARS-CoV-2 infection, and that a vast majority of these patients (96.6%) have abnormal chest CT examination. The incidence of fever was estimated at 89.1%, the incidence of cough 72.2%, and the incidence of muscle soreness or fatigue 42.5%. In this analysis, the incidence of acute respiratory distress syndrome (ARDS) reached 14.8%. ARDS is the most severe form of acute lung injury (Cheng, Wang et al. J Med Vir 2020, see ***below***). It is characterized mainly by increased pulmonary vascular permeability and pulmonary oedema. It is often induced by sepsis, aspiration, and pneumonia (including that caused by SARS coronavirus and human influenza viruses). It is a clinical, high-death-rate disease.

Diarrhoea, haemoptysis, headache, sore throat, shock, and other symptoms were reported to occur only in a small number of patients.

Of note, Sun (J Med Vir 2020, see ***below***) reported a definition of fever as temperature ≥ 37.3°C. He did not provide details on the method of temperature recording (e.g. axillary, forehead or sublingual). This definition was indeed reported for instance by Song (Radiol 2020). By contrast, Guan (NEJM 2020, see ***below***) mentioned a definition of fever as an axillary temperature of 37.5°C or higher. Such discrepancies can be expected to result in some variability across hospitals with regard to the detection of this symptom.

Another metaanalysis by Li (J Med Vir 2020, see ***below***), including a somewhat different set of ten studies[2] found the main clinical symptoms of COVID-19 patients to be fever (88.5%), cough (68.6%), myalgia or fatigue (35.8%),

[1] Huang Lancet 2020; Wang JAMA 2020 ; Chen Lancet 2020; Guan NEJM 2020 ; Chen Zhonghua Jie He He Hu Xi Za Zhi.; Sun, Lancet 2020; Yang medRxiv 2020 (manuscript subsequently withdrawn); Li medRxiv 2020; The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team, Chinese Center for Disease Control and Prevention. Zhong Hua Liu Xing Bing Xue Za Zhi 2020; Xu BMJ 2020.

[2] Huang Lancet 2020; Chang JAMA 2020; Guan NEJM 2020; Wang JAMA 2020; Li N Engl J Med 2020; Chen Lancet 2020; Wang Biosci Trends 2020; Kui Chin Med J 2020; Lei Chin J Tuberc Resp Dis 2020; Mingqiang Chin Med J 2020.

expectoration (28.2%), and dyspnoea (21.9%). In addition to common respiratory symptoms, the symptoms of headache or dizziness (12.1%), diarrhoea (4.8%), nausea, and vomiting (3.9%) were also obvious in some patients.

A third metaanalysis by Rodriguez-Morales (Trav Med Inf Dis 2020, see ***below***) found that in 656 patients, fever (88.7%, 95%CI 84.5-92.9%), cough (57.6%, 40.8-74.4%) and dyspnea (45.6%, 10.9-80.4%) were the most prevalent manifestations. Among the patients, 20.3% (95%CI 10.0-30.6%) required intensive care unit (ICU), 32.8% presented with ARDS (95%CI 13.7-51.8), 6.2% (95%CI 3.1-9.3) with shock. Some 13.9% (95%CI 6.2-21.5%) of hospitalized patients had fatal outcome.

A review by Borges do Nascimento (J Clin Med 2020, see ***below***), covering a total of 61 studies (59,254 patients), provided another metaanalysis of available clinical data. The most common disease-related symptoms were fever (82%, 95% confidence interval (CI) 56%–99%; n = 4410), cough (61%, 95% CI 39%–81%; n = 3985), muscle aches and/or fatigue (36%, 95% CI 18%–55%; n = 3778), dyspnea (26%, 95% CI 12%–41%; n = 3700), headache in 12% (95% CI 4%–23%, n = 3598 patients), sore throat in 10% (95% CI 5%–17%, n = 1387) and gastrointestinal symptoms in 9% (95% CI 3%–17%, n = 1744).

A relevant feature of COVID-19, not addressed by the metaanalyses, is the absence of dyspnea, observed even in the most severe cases, in which subjects present tachypnea and tachycardia (Bertran Recasens Eur J Neurol. 2020, see ***below***). In the Wuhan cohort, 62.4% of severe cases and 46.3% of those who ended up intubated, ventilated or dead did not present dyspnea.

Less frequent observations

Hu (Eur Heart J, see ***below***) presented a COVID-19 case with fulminant myocarditis with cardiogenic shock. This clinical presentation had initially been reported to be rare, but was subsequently better recognized. A review by Bansal (Diabetes Metab Syndr. 2020, see ***below***) indicated that acute cardiac injury, defined as significant elevation of cardiac troponins, is the most commonly reported cardiac abnormality in COVID-19. It occurs in approximately 8-12% of all patients. Direct myocardial injury due to viral involvement of cardiomyocytes and the effect of systemic inflammation appear to be the most common mechanisms responsible for cardiac injury.

Of note, while expression of the ACE2 receptor in kidney and bladder had suggested the possibility of renal involvement in COVID-19, Wang (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.19.20025288v1) analysed data from 116 hospitalized patients, and concluded that acute renal impairment was uncommon in COVID-19, and that there was no aggravation of chronic renal failure observed in this cohort.

Although abnormalities of liver function indexes are common in COVID-19 patients, based on a retrospective study conducted on 115 confirmed cases, the impairment of liver function was not found by Zhang (Liver Int 2020, see ***below***) to be a prominent feature of COVID-19.

A report by Zhao (Lancet Neurol 2020, see ***below***) described a case of SARS-CoV-2 infection associated with Guillain-Barré syndrome.

Clinical disease outside China

Descriptions of cases that occurred outside China are also available. For instance:

- Ki (Epidemiol Health 2020) described the early cases identified in Korea,
- Holshue the first case in the United States of America (USA) (New Engl J Med 2020, see ***below***), and Harcourt (Emerg Infect Dis 2020, see ***below***) the virus isolation from this patients and its characterization,
- Arentz (JAMA 2020, see ***below***) 21 critically Ill patients with COVID-19 in Washington State, USA
- Bastola (Lancet Inf Dis 2020, see ***below***) and Shrestha (J Travel Med 2020, see ***below***) the first case in Nepal,

- Silverstein (Lancet 2020, see ***below***) and Marchand-Senecal (Clin Inf Dis 2020, see ***below***) described the first imported case in Canada.
- Van Cuong (Lancet Inf Dis 2020, see ***below***) the first case in Vietnam
- Cheng (J Formos Med Assoc 2020, see ***below***) described the first case in Taiwan
- Huang (J Micr Imm Inf 2020, see ***below***) described 2 cases in Taiwan
- Lillie (J Inf 2020, see ***below***) described 2 cases in the UK with person to person transmission
- Young (JAMA 2020, see ***below***) described the case series of the first 18 patients with PCR-confirmed SARS-CoV-2 infection at 4 hospitals in Singapore from January 23 to February 3, 2020
- The COVID-19 National Emergency Response Center (Osong Public Health Res Perspect 2020, see ***below***) presented 28 cases in South Korea.
- Bernard Stoecklin (Eurosurv 2020, see ***below***) and Lescure (Lancet Inf Dis 2020, see ***below***) presented the first cases in France
- Pongpirul (Emerg Infect Dis. 2020, see ***below***) described 11 cases in Thailand
- Goyal (NEJM 2020, see ***below***) described the key characteristics of 393 patients in New York

Spiteri (Euro Surv 2020: https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.9.2000178) described the first cases detected in Europe, excluding cases reported in the United Kingdom (UK), as at 21 February 2020. The analysis included both sporadic cases among travellers from China (14 cases) and cases who acquired infection due to subsequent local transmission in Europe (21 cases). The clinical presentation observed in the cases in Europe is that of an acute respiratory infection. However, of the 31 cases with information on symptoms, 20 cases presented with fever and nine cases presented only with fever and no other symptoms.

Non-respiratory symptoms

Cardiac manifestations

A metaanalysis by Li (Prog Cardiovasc Dis 2020, see ***below***) found acute cardiac injury more frequent in those with severe, compared to milder, disease (risk ratio 5.99, 3.04 to 11.80; $p < 0.001$). Meta-regression suggested that cardiac injury biomarker differences of severity are related to a history of hypertension ($p = 0.030$). In addition, COVID19-related cardiac injury was associated with higher mortality (summary risk ratio 3.85, 2.13 to 6.96; $p < 0.001$). hsTnI and NT-proBNP levels increased during the course of hospitalization only in non-survivors.

Gastrointestinal symptoms

A U.S. case-control study among the 278 COVID-19 positive patients showed 35% of patients had gastrointestinal symptoms (Nobel Gastroenterology 2020, see ***below***)

Skin disorders

Searching for evidence of skin involvement of COVID-19, Recalcati (J Eur Acad Dermatol Venereol 2020, see ***below***) retrospectively analysed 88 patients, of which 18 patients (20.4%) developed cutaneous manifestations: 8 patients developed cutaneous involvement at the onset, 10 patients after the hospitalization. Cutaneous manifestations were erythematous rash (14 patients), widespread urticaria (3 patients) and chickenpox-like vesicles (1 patient). This is the first report of this kind. Confirmation that these lesions are caused by the virus remains to be obtained.

Joob (J Am Acad Dermatol 2020, see ***below***) also provided a case report from Thailand where the patient presented a skin rash with petechiae. Other common virus infections that might cause fever, rash and respiratory problem were ruled out by laboratory investigation and the final diagnosis of COVID-19 infection was by RT-PCR.

Zulfiqar (NEJM 2020, see ***below***) described a case of thrombocytopenic purpura in a female patient with COVID-19. The temporal sequence in this case suggested, but did not prove, that COVID-19 was a causal factor.

Venous thromboembolism

While alterations of the coagulation pathways had soon been detected by clinical laboratory analyses, reports of thromboembolism related to COVID-19 appeared a few weeks later in the scientific literature.

- Davoodi (preprint available at Research Square: https://www.researchsquare.com/article/rs-21602/v1) reported a case of deep vein thrombosis in a 57-year-old woman presenting with pain, redness, and leg swelling, who was then diagnosed with COVID-19.
- Chen (non-peer-reviewed manuscript available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3548771) presented a retrospective analysis of 25 patients confirmed COVID-19 pneumonia who also underwent CT pulmonary angiography scans. Ten patients were acute pulmonary embolism positive as presented on CT pulmonary angiography and the median D-dimer level was 11.07ug/ml (IQR, 7.12-21.66); acute pulmonary embolism in these patients was found dominantly located in small branches of the pulmonary artery. Fifteen patients were acute pulmonary embolism negative and median D-dimer levels was 2.44ug/ml (IQR, 1.68-8.34). Lymphopenia (lymphocyte count, median 0.81×10^9 /L, IQR, $0.55\text{-}1.05\times10^9$ /L) mostly occurred in 19 patients (76%). Serum CRP and B-type BNP were frequently increased and Albumin and PaO2 decreased among the 25 patients; however except for D-dimer, no significant differences in laboratory data were found between these two groups.
- Cui (J Thromb Haemost. 2020, see ***below***) found an incidence of 25% (20/81) venous thromboembolism among patients with severe disease; 8 of these patients with venous thromboembolism events died. The venous thromboembolism group was different from the non-venous thromboembolism group in age, lymphocytes counts, activated partial thromboplastin time (APTT), D-dimer, etc. If 1.5 μg/mL was used as the D-dimer cut-off value to predicting venous thromboembolism, the sensitivity was 85.0%, the specificity was 88.5% and the negative predictive value (NPV) was 94.7%.
- The incidence of thrombotic complications (composite outcome of symptomatic acute pulmonary embolism, deep-vein thrombosis, ischemic stroke, myocardial infarction or systemic arterial embolism) was studied in 184 ICU patients with proven COVID-19 pneumonia at 3 Dutch hospitals (Klok Thrombosis Res 2020: https://www.sciencedirect.com/science/article/pii/S0049384820301201). All patients received at least standard dose thromboprophylaxis. The cumulative incidence of the composite outcome was 31% (95%CI 20-41), of which CT pulmonary angiography and/or ultrasonography confirmed venous thromboembolismin 27% (95%CI 17-37%) and arterial thrombotic events in 3.7% (95%CI 0-8.2%). Acute pulmonary embolism was the most frequent thrombotic complication (n = 25, 81%). In this study, age (adjusted hazard ratio (aHR) 1.05/per year, 95%CI 1.004-1.01) and coagulopathy, defined as spontaneous prolongation of the prothrombin time > 3 s or activated partial thromboplastin time > 5 s (aHR 4.1, 95%CI 1.9-9.1), were independent predictors of thrombotic complications.
- A retrospective study conducted in France evaluated 26 consecutive patients with severe COVID-19 (Llitjos J Thromb Haemost 2020, see ***below***). Eight of these patients (31%) were treated with prophylactic anticoagulation whereas 18 patients (69%) were treated with therapeutic anticoagulation. The overall rate of venous thromboembolic events in patients was 69%. The proportion of venous thromboembolic events was significantly higher in patients treated with prophylactic anticoagulation when compared to the other group (100% vs. 56%, respectively, p=0.03). Surprisingly, the authors found a high rate of thromboembolic events in COVID-19 patients treated with therapeutic anticoagulation, with 56% of venous thromboembolic events and 6 pulmonary embolisms.

Central nervous system manifestations

Asadi-Pooya (J Neurol Sci 2020, see ***below***) provided a systematic review on central nervous system manifestations of COVID-19. While neurological manifestations of COVID-19 have not been studied appropriately, the authors considered highly likely that some of these patients, particularly those who suffer from a severe illness, have CNS involvement and neurological manifestations.

Taste and olfactory disorders

Multiple reports in the media in March 2020 associated anosmia and dysgeusia with COVID-19 (see for instance, https://www.sciencealert.com/mild-covid-19-might-cause-a-lost-of-smell-or-taste; or https://edition.cnn.com/2020/03/23/health/coronavirus-symptoms-smell-intl/index.html). Giacomelli (Clin Inf Dis 2020, see ***below***) performed a cross-sectional survey of the prevalence of olfactory and taste disorders in the context of SARS-CoV-2 infection. Twenty (33.9%) reported at least one taste or olfactory disorder and 11 (18.6%) both. Twelve patients (20.3%) presented the symptoms before the hospital admission, whereas 8 (13.5%) experienced the symptoms during the hospital stay. Taste alterations were more frequently (91%) before hospitalization, whereas after hospitalization taste and olfactory alteration appeared with equal frequency. Mao (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.22.20026500v1.full.pdf) reported hypogeusia in 12 [5.6%]) and hyposmia in 11 out of 214 patients [5.1%]). A study by Lechien (Eur Arch Otorhinolaryngol 2020, see ***below***) involved 417 mild-to-moderate COVID-19 patients. Face pain and nasal obstruction were the most disease-related otolaryngological symptoms in this cohort. 85.6% and 88.0% of patients reported olfactory and gustatory dysfunctions, respectively. There was a significant association between both disorders ($p < 0.001$). Olfactory dysfunction appeared before the other symptoms in 11.8% of cases. Among the 18.2% of patients without nasal obstruction or rhinorrhoea, 79.7% were hyposmic or anosmic. The early olfactory recovery rate was 44.0%. Females were significantly more affected by olfactory and gustatory dysfunctions than males ($p = 0.001$).

Eliezer (JAMA Otolaryngol Head Neck Surg 2020, see ***below***) presented a case where the main symptom expressed by the patient infected by SARS-CoV-2 was the sudden and complete loss of the olfactory function without nasal obstruction. CT scan of the nasal cavity that showed bilateral inflammatory obstruction of the olfactory clefts that was confirmed on magnetic resonance imaging of the nasal cavity. There were no anomalies of the olfactory bulbs and tracts. Similarly, Galougahi (Acad Radiol 2020, see ***below***) found normal olfactory bulb volume without abnormal signal intensity in the olfactory bulb and tract and no sign of nasal congestion by magnetic resonance. This finding is consistent with prior reports of SARS-CoV-induced anosmia, where olfactory bulb MRI similarly did not demonstrate abnormal findings. The authors suggested further investigations incl. longitudinal MRI both in the acute and in follow-up phases of the disease.

Of note, Gane (Rhinology 2020, see ***below***) reported a case characterized by sudden onset anosmia in a COVID-19 confirmed patient who did not develop any further symptoms. Based on a survey of 2428 patients reporting new onset anosmia during the COVID-19 pandemic, Hopkins (Rhinology 2020, see ***below***) concluded that 1 in 6 patients with recent onset anosmia reports this as an isolated symptom. COVID-19 testing was not performed in this study, but the authors recommended additional studies to further investigate the link between this symptom and the virus.

Guillain-Barre Syndrome

Toscano (NEJM 2020, see ***below***) examined five patients who had Guillain–Barré syndrome after the onset of COVID-19. The findings were generally consistent with an axonal variant of Guillain–Barré syndrome in three patients and with a demyelinating process in two patients. The authors reported that they could not determine whether severe deficits and axonal involvement are typical features of COVID-19–associated Guillain–Barré syndrome. An additional case observed in Iran was reported by Sedaghat (J Clin Neurosci 2020, see ***below***), and a case in the U.S.A. presented by Virani (IDCases 2020, see ***below***).

Clinical imaging

Chest computed tomography

A number of reports provide a detailed description of chest computed tomography (CT) scan findings of patients with COVID-19 pneumonia. For instance:

- Kong Radiol 2020 on https://pubs.rsna.org/doi/full/10.1148/ryct.2020200028;

- Li Radiol 2020 on https://pubs.rsna.org/doi/full/10.1148/ryct.2020200026;
- Ng Radiol 2020 on https://pubs.rsna.org/doi/full/10.1148/ryct.2020200034;
- Song Radiol 2020, see ***below***
- Chung Radiol 2020, see ***below***
- Bernheim Radiol 2020, see ***below***
- Yoon Korean J Radiol 2020, see ***below***
- Xu Eur J Nucl Med Mol Imaging 2020, see ***below***
- Yang (J Inf 2020, see ***below***) presented clinical imaging data from 149 RT-PCR confirmed positive patients in three tertiary hospitals of Wenzhou.
- Shi Lancet Inf Dis 2020, see ***below***
- Xu (J Inf 2020, see ***below***) described data from 50 patients, including mild type, common, severe and critically severe cases.
- Albarello (Int J Infect Dis 2020, see ***below***) presented the CT findings in 2 cases in Italy.
- Li and Xia (AJR Am J Roentgenol 2020, see ***below***) described 51 cases in Wuhan.
- Zhou (AJR Am J Roentgenol 2020, see ***below***) described CT findings in 62 patients in Wuhan.
- Xiong (Invest Radiol 2020, see ***below***) described 42 cases in Wuhan including cases with progressive disease features.
- Zhu (J Inf 2020, see ***below***) described 6 cases in Guangzhou.
- Li (Ped Radiol 2020, see ***below***) presented CT findings from 5 children at a large tertiary-care hospital in China with positive RT-PCR for COVID-19.
- Xia (Pedriatr Pulmonol 2020, see ***below***) described 20 paediatric patients , of which 6 presented with unilateral pulmonary lesions (6/20, 30%), 10 with bilateral pulmonary lesions (10/20, 50%), and 4 showed no abnormality on chest CT (4/20, 20%).
- Zhao (Clin Radiol 2020, see ***below***) presented chest CT images of 80 patients in China.

Guan (NEJM 2020, see ***below***) found that on admission ground-glass opacity (see Figure 5) was the typical radiological finding on chest CT (50.00%, in a dataset of 1 099 patients with laboratory-confirmed disease). The typical radiological imaging of COVID-19 pneumonia demonstrated destruction of the pulmonary parenchyma including interstitial inflammation and extensive consolidation, similar to SARS (Pan Radiol 2020, see ***below***). However, some patients with COVID-19 pneumonia consistently demonstrated no hypoxemia or respiratory distress during the course of hospitalization. A study in 21 patients recovering from COVID-19 pneumonia (without severe respiratory distress during the disease course) showed that lung abnormalities on chest CT showed greatest severity approximately 10 days after initial onset of symptoms. Dai (Can Assoc Radiol 2020, see ***below***) also discussed the difference between COVID-19 and other lung diseases.

Zhang (Int Care Med 2020, see ***below***) observed white “Septal Lines” in a 75-year-old male confirmed with severe COVID-19 pneumonia, suggesting that cellulosic exudation occurred at the surface of lung lobes.

Salehi (AJR Am J Roentgenol 2020, see ***below***) published a systematic review of imaging findings in 919 patients. The authors found the characteristic patterns and distribution of CT manifestations: ground glass opacification (GGO) (88.0%), bilateral involvement (87.5%), peripheral distribution (76.0%), and multilobar (more than one lobe) involvement (78.8%) (Table 7). Isolated GGO or a combination of GGO and consolidative opacities were some of the most common CT findings. Other CT findings included interlobular septal thickening, bronchiectasis, pleural thickening, and subpleural involvement, with various rates across the studies. Pleural effusion, pericardial effusion, lymphadenopathy, cavitation, CT halo sign, and pneumothorax were less common or rare.

Figure 5 CT lung imaging from a 41-year-old woman who tested positive for COVID-19. This 3-D reconstruction shows multifocal ground glass opacities without consolidation (from https://www.itnonline.com/content/radiologists-describe-coronavirus-ct-imaging-features).

Table 7 Common Patterns and Distribution on Initial CT Images of 919 Patients With COVID-19 (from Salehi AJR AM J Roentgenol 2020)

Imaging Finding	No. of Studies	No. (%) of Reported Cases/ Total No. of Patients
Bilateral involvement	12	435/497 (87.5)
Peripheral distribution	12	92/121 (76.0)
Posterior involvement	1	41/51 (80.4)
Multilobar involvement	5	108/137 (78.8)
Ground-glass opacification	22	346/393 (88.0)
Consolidation	10	65/204 (31.8)

Qin (Eur J Nucl Med Mol Imaging 2020, see ***below***) described for the first time the 18F-FDG PET/CT findings of four patients with COVID-19. The data confirmed previous observations of peripheral ground-glass opacities and/or lung consolidations (in more than two pulmonary lobes). Lung lesions were characterized by a high 18F-FDG uptake and there was evidence of lymph node involvement. Conversely, disseminated disease was absent, a finding suggesting that COVID-19 has pulmonary tropism.

Following the evaluation of 80 patients, Wu (Invest Radiol 2020, see ***below***) suggested significant correlations between the degree of pulmonary inflammation and the main clinical symptoms and laboratory results. Similarly, Zhao (AJR Am J Roentgenol 2020, see ***below***) investigated the relationship between chest CT findings and the clinical condition of 101 patients with COVID-19 pneumonia in Hunan, China, and found that architectural distortion, traction bronchiectasis, and CT involvement score aided in the evaluation of the severity and extent of the disease.

Based on a retrospective analysis of 27 consecutive patients, Yuan (PLoS One 2020, see ***below***) found that a simple CT scoring method was able to predict mortality.

Lung ultrasound

Chest CT has thus acquired a pivotal role for the diagnosis and assessment of lung involvement in COVID-19, and CT protocols are used to estimate the pulmonary damage. Unfortunately, CT scanning is not available in all emergency departments. Lung ultrasound is a surface imaging technique greatly developed in the last decades and strongly recommended for acute respiratory failure. Poggiali (Radiol 2020, see ***below***) presented preliminary data from 12

patients suggesting the feasibility of using bedside ultrasound for the early diagnosis of COVID-19 pneumonia. A recommendation for more studies on this topic was also made by Soldati (J Ultrasound Med 2020, see ***below***), who presented data from 2 additional cases. However, a study by Lu (Ultraschall Med 2020, see ***below***) showed moderate agreement (Kappa = 0.529) between bedside ultrasound for lung lesions and CT in patients with COVID-19. The ultrasound scores to evaluate mild, moderate and severe lung lesions exhibited sensitivity of 68.8% (11/16), 77.8% (7/9), 100.0% (2/2), specificity of 85.7% (12/14), 76.2% (16/21), 92.9% (26/28), and diagnostic accuracy of 76.7% (23/30), 76.7% (23/30), 93.3% (28/30), respectively.

A standardized approach has been proposed to optimize the use of lung ultrasound in COVID-19 patients (Soldati, Smargiassi et al. J Ultrasound Med 2020, see ***below***). Moreover, a panel of international experts evaluated the position of ultrasound in the management of COVID-19 and summarized benefits, open questions and challenges in the setting of the COVID-19 epidemic (Ultraschall Med 2020, see ***below***).

Laboratory finding & biomarkers

A number of reports present the laboratory observations associated with COVID-19. Various studies addressed the search for a prognostic marker of severe infection, while others focused on understanding pathological mechanisms.

Virus load

A number of reports analysed the virus load in respiratory secretions of COVID-19 patients (using RT-PCR). Key findings related to virus detection in patients are illustrated below.

Virus load and disease severity

The viral load detected from the respiratory tract of patients was soon positively linked to lung disease severity (Liu Sci China Life Sci 2020, see ***below***), and subsequent studies confirmed this observation. Liu (Lancet Inf Dis 2020, see ***below***) presented data from 76 patients suggesting that the viral load of SARS-CoV-2 might be a useful marker for assessing disease severity and prognosis. The mean viral load of severe cases was indeed around 60 times higher than that of mild cases.

However, Lescure (Lancet Inf Dis 2020, see ***below***) observed high nasopharyngeal virus load within the first 24 h of illness onset (5.2 and 7.4 log10 copies per 1000 cells, respectively), in 2 patients with few symptoms.

Of note, older age was correlated with higher viral load (Spearman's ρ=0·48, 95% CI 0·074-0·75; p=0·020) in a study by To (Lancet inf Dis 2020, see ***below***). However, a study by Zhou (Clin Infect Dis 2020, see ***below***) did not reach the same conclusion when comparing patients <65 yrs [31.0 (IQR: 23.5-40.5) days] to those ≥65 yrs [31.0 (IQR: 24.3-38.0) days)].

Virus load in different types of specimens

Presence of the virus in different types of clinical specimens was also analysed. Pan (Lancet Inf Dis 2020, see ***below***) for instance, reported such analysis from 82 infected individuals. The data can be summarized as follows:

- In 2 patients monitored daily, the viral loads in throat swab and sputum samples peaked at around 5-6 days after symptom onset, ranging from around 10^4 to 10^7 copies per mL during this time.
- In individuals at different stages of infection, viral loads ranged from 641 copies per mL to 1.34×10^{11} copies per mL, with a median of 7.99×10^4 in throat samples and 7.52×10^5 in sputum samples.
- A sputum sample collected on day 8 post-onset from a patient who died had a very high viral load ($1{\cdot}34 \times 10^{11}$ copies per mL).
- Notably, two individuals, who were under active surveillance because of a history of exposure to infected patients showed positive results on RT-PCR a day before onset, suggesting that infected individuals can be infectious before them become symptomatic.

- From 17 confirmed cases with available data (representing days 0–13 after onset), stool samples from nine (53%; days 0–11 after onset) were positive on RT-PCR analysis, but with lower viral loads than respiratory samples.

Another study by Chen, Lan et al. (Em Micr Inf 2020, see ***below***) found detectable SARS-CoV-2 RNA was in the blood of 6 of 57 patients. Importantly, all of these 6 patients progressed to severe symptom stage, indicating a strong correlation of serum viral RNA with disease severity (p-value = 0.0001).

Kinetic studies

In the cohort of 191 patients with laboratory-confirmed disease described by Zhou (Lancet 2020, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext), duration of viral shedding ranged between 8 and 37 days. The median duration of viral shedding was 20·0 days (IQR 17·0–24·0) in survivors, but continued until death in fatal cases.

In the study by Liu (Lancet Inf Dis 2020, see ***below***), the viral load of severe cases remained significantly higher for the first 12 days after onset than those of corresponding mild cases. Mild cases were also found to have an early viral clearance, with 90% of these patients repeatedly testing negative on RT-PCR by day 10 post-onset. By contrast, all severe cases still tested positive at or beyond day 10 post-onset.

From a small series of 8 patients with mild to moderate disease, Ma (J Microbiol Immunol Infect 2020, see ***below***) suggested that stool specimens of children may remain PCR-positive for a longer time than those of adults.

Chang (Am J Respir Crit Care Med 2020, see ***below***) determined the time kinetics of viral clearance in reference to the resolution of symptoms in 16 patients treated in Beijing, China, and showed that half of the patients with COVID-19 were viral positive even after resolution of their symptoms.

A study by To (Lancet inf Dis 2020, see ***below***) in 23 patients with COVID-19 showed a median viral load in posterior oropharyngeal saliva or other respiratory specimens at presentation of 5·2 log10 copies per mL (IQR 4·1-7·0). Salivary viral load was highest during the first week after symptom onset and subsequently declined with time (slope -0·15, 95% CI -0·19 to -0·11; R2=0·71). In one patient, viral RNA was detected 25 days after symptom onset.

Wölfel (Nature 2020, see ***below***) provided a detailed virological analysis of nine COVID-19 cases. Pharyngeal virus shedding was very high during the first week of symptoms (peak at 7.11×10^8 RNA copies per throat swab, day 4). **Infectious virus** was readily isolated from throat- and lung-derived samples, but not from stool samples, in spite of high virus RNA concentration. Blood and urine never yielded virus. Active replication in the throat was confirmed by viral replicative RNA intermediates in throat samples. Sequence-distinct virus populations were consistently detected in throat and lung samples from the same patient, proving independent replication. Shedding of viral RNA from sputum outlasted the end of symptoms. Of note, seroconversion occurred after 7 days in 50% of these patients (14 days in all), but was not followed by a rapid decline in viral load.

Yuan (Inflamm Res 2020, see ***below***) presented a kinetic view of viral load, cell count and biochemical parameters in patients with mild/moderate and severe disease. The authors also observed that COVID-19 mRNA clearance ratio was significantly correlated with the decline of serum creatine kinase (CK) and lactate dehydrogenase (LDH) levels, which may then predict a favourable response to treatment.

Cell counts

A manuscript by Liu based on the monitoring of 61 patients suggests the **neutrophil/lymphocyte ratio** as a predictive marker of severe illness. This biomarker proved superior to the MuLBSTA score that had been suggested before for COVID-19 patients monitoring. https://www.medrxiv.org/content/10.1101/2020.02.10.20021584v1.full.pdf. A

subsequent report from data in 40 patients confirmed this conclusion (https://www.medrxiv.org/content/10.1101/2020.02.16.20023671v1).

Chen (J Clin Invest 2020, see ***below***) reported significantly lower **lymphocyte counts** in severe cases (0.7 × 109 125 /L) than moderate cases (1.1 × 109/L). Absolute number of T lymphocytes, CD4+T and CD8+T cells decreased in nearly all the patients, and were markedly lower in severe cases (294.0, 177.5 and 89.0 × 10^6/L) than moderate cases (640.5, 381.5 and 254.0 × 10^6/L). The expressions of IFN-γ by CD4+T cells tended to be lower in severe cases (14.1%) than moderate cases (22.8%).

A study by Zheng (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.19.20024885v1) investigated differences in laboratory parameters between 103 COVID-19 and 22 non-COVID-19 pneumonia cases. The lymphocyte subsets counts were found to exhibit a significant negative correlation with biochemical indices relating to organ injury in the COVID-19 infected patients.

Similarly, Zeng (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.03.08.20031229v1.full.pdf) described a phenomenon of lymphocyte depletion (PLD) observed in 100% severe or critical cases (ICU). As the disease progressed and clinical status deteriorated, levels of lymphocytes were found progressively decreased before death.

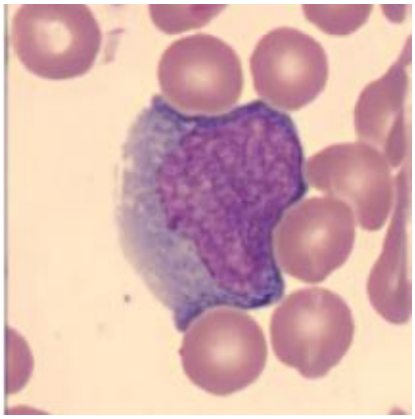
A study by Tan (Signal Transduct Target Ther 2020, see ***below***) confirmed the observation of lymphopenia. Lymphocyte counts in severe patients were found to decrease initially and then increase to higher than 10% until discharge. In contrast, the lymphocyte count of moderate patients fluctuated very little after disease onset and was higher than 20% upon discharge. These results suggest that lymphopenia is a predictor of prognosis in COVID-19 patients.

Based on the observation that **eosinopenia** is frequently observed in COVID-19 patients (79% in SARS-CoV-2 positive patients vs. 36% in SARS-CoV-2 negative patients, Li (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.13.20022830v1) suggested an alternative, simple, approach to facilitate triage of patients. The approach led to a diagnosis sensitivity and specificity of 79% and 64%, respectively. Zhang (Allergy 2020, see ***below***) also reported eosinopenia in most patients, but the frequency of the observation (52.9%) does not support the diagnostic value of this marker.

Qin (Clin Inf Dis 2020, see ***below***) described 452 patients who underwent laboratory examinations on admission. Similar to previous reports, the authors reported that severe cases tend to have lower lymphocytes counts, higher leukocytes counts and neutrophil-lymphocyte-ratio (NLR), as well as lower percentages of monocytes, eosinophils, and basophils. Most of severe cases demonstrated elevated levels of infection-related biomarkers and inflammatory cytokines. Lymphocyte subsets were analyzed in 44 patients with COVID-19 on admission. The total number of B cells, T cells and NK cells were significantly decreased in patients with COVID-19, and particularly in severe cases. The percentage of naïve helper T cells (CD3+CD4+CD45RA+) increased and memory helper T cells (CD3+CD4+CD45RO+) were found decreased in severe cases.

Chong (Br J Haematol 2020, see ***below***) found reactive lymphocytes in 23/32 confirmed COVID-19 cases (72%) (Figure 6 Reactive lymphocyte in a COVID-19 patient (from Chong Br J Haematol 2020)). This is in stark contrast to the 2003 SARS where reactive lymphocytes of this type were not present in a review of 185 cases in Singapore and were present in only 15.2% of 138 cases in Hong Kong.

Figure 6 Reactive lymphocyte in a COVID-19 patient (from Chong Br J Haematol 2020)



Similarly, Foldes (Am J Hematol 2020, see ***below***) reported atypical lymphocytes that appeared reactive in a patient. Prominent among these were lymphoplasmacytoid lymphocytes with an eccentric nucleus, deeply basophilic cytoplasm and a prominent paranuclear hof.

Biochemistry

Elevated C-reactive protein (**CRP**) is an important feature of COVID-19 (Zhang Lancet Resp Med 2020, see ***below***). A study in 12 patients (Liu Sci China Life Sci 2020, see ***below***) found blood biochemistry indexes, albumin (ALB), CRP, lactate dehydrogenase (LDH), may be predictors of disease severity. Similarly, Liu (Chin Med J 2020, see ***below***) found CRP to be significantly elevated in a progression group compared to another group of patients with improvement/stabilization (38.9 [14.3, 64.8] vs. 10.6 [1.9, 33.1] mg/L, U = 1.315, P = 0.024). Albumin was significantly lower in the progression group than in the improvement/stabilization group (36.62 ± 6.60 vs. 41.27 ± 4.55 g/L, U = 2.843, P = 0.006).

In a cohort of 132 COVID-19 patients, Li (J Infect 2020, see ***below***) observed significantly increased serum amyloid A (**SAA**) and CRP levels. As disease progressed from mild to critically severe, SAA and CRP gradually increased, while lymphocyte counts decreased; a ROC curve analysis suggested that SAA/lymphocyte counts, CRP, SAA, and lymphocyte counts are valuable in evaluating the severity of COVID-19 and distinguishing critically ill patients from mild ones; patients with SAA consistently trending down during the course of disease had better prognosis, compared with patients with SAA continuously rising. Patient with higher initial SAA level were also more likely to have poor CT imaging.

A manuscript by Fan (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.26.20026971v1.full.pdf) describes a cohort of 148 patients, of which (50.7%) showed abnormal **liver function** at admission, characterized by increased ALT, AST, GGT, AKP.

Alanine aminotransferase, LDH levels, high-sensitivity CRP and ferritin were significantly higher in severe cases (41.4 U/L, 567.2 U/L, 135.2 mg/L and 1734.4 ug/L) than moderate cases (17.6 U/L, 234.4 U/L, 51.4 mg/L and 880.2 ug /L) (Chen (on MedRxiv https://www.medrxiv.org/content/10.1101/2020.02.16.20023903v1). IL-2R, TNF-α and IL-10 concentrations on admission were significantly higher in severe cases (1202.4 pg/mL, 10.9 pg/mL and 10.9 pg/mL) than moderate cases (441.7 pg/mL, 7.5 pg/mL and 6.6 pg/mL).

Moreover, the **angiotensin II** level in the plasma sample from COVID-19 patients has been found markedly elevated and linearly associated to viral load and lung injury (Liu Sci China Life Sci 2020, see ***below***).

A metaanalysis by Lippi (Clin Chim Acta 2020, see ***below***) showed that increased **procalcitonin** values are associated with a nearly 5-fold higher risk of severe SARS-CoV-2 infection (OR, 4.76; 95% CI, 2.74-8.29). The heterogeneity

among the different studies was found to be modest (i.e., 34%). As the synthesis of this biomarker is inhibited by INF-γ, whose concentration is expected to increase during viral infections, the authors speculate that increased procalcitonin could reflect bacterial superinfection in severe disease cases. However, more investigations are still needed to identify the origin of the biomarker.

Another metaanalysis by Lippi (Prog Cardiovasc Dis 2020, see ***below***) assessed **cardiac troponin I** (cTnI) in patients with COVID-19. Although the heterogeneity was considerably high, the values of cTnI were found to be significantly increased in patients with severe disease than in those without (SMD, 25.6 ng/L; 95% CI, 6.8–44.5 ng/L).

A metaanalysis by Henry (Clin Chem Lab Med. 2020, see ***below***) identified IL-6, IL-10 and serum ferritin as strong discriminators for severe disease.

A nice review by Terpos (Am J Hematol 2020, see ***below***) provided a clear picture of the laboratory findings associated with COVID-19. Evidence was presented to support that various parameters have potential as predictive parameters for severity: lymphopenia, thrombocytopenia and neutrophilia (raised neutrophils) not only predict ARDS, but also cardiovascular complications. Raised procalcitonin, ferritin, LDH, IL-6 and CRP and the coagulation disorders (D-dimer, increased fibrin degradation, PTT and aPT) were also highlighted.

Coagulation parameters

Tang (J Thromb Haemost 2020, see ***below***) described the coagulation data of 183 consecutive patients with confirmed COVID-19 pneumonia. The non-survivors revealed significantly higher D-dimer and fibrin degradation product (FDP) levels, longer prothrombin time and activated partial thromboplastin time compared to survivors on admission (P<0.05). 71.4% of non-survivors and 0.6% survivors met the criteria of disseminated intravascular coagulation during their hospital stay.

Zhou (Lancet 2020, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext) found increasing odds of in-hospital death associated with **D-dimer** levels greater than 1·0 µg/L (18·42, 2·64–128·55; p=0·0033) on admission. Gao (J Med Vir 2020: https://onlinelibrary.wiley.com/doi/abs/10.1002/jmv.25770) found that IL-6 and D-Dimer were closely related to the occurrence of severe COVID-19 in adult patients, and their combined detection had the highest specificity and sensitivity for early prediction of the severity of disease. In this study in 43 patients, the specificity of predicting the severity of COVID-19 during IL-6 and D-Dimer tandem testing was up to 93.3%, while the sensitivity of such testing reached 96.4%.

A metaanalysis by Lippi (Clin Chim Acta 2020, see ***below***) included 1779 COVID-19 patients, of whom 399 (22.4%) had severe disease. The pooled analysis revealed that platelet count was significantly lower in patients with more severe COVID-19 (WMD -31×10^9/L; 95% CI, from -35 to -29×10^9/L). A subgroup analysis comparing patients by survival, found an even lower platelet count observed with mortality (WMD, -48×10^9/L; 95% CI, -57 to -39×10^9/L. In the four studies which reported data on rate of **thrombocytopenia** (n=1427), a low platelet count was associated with over five-fold enhanced risk of severe COVID-19 (OR, 5.1; 95% CI, 1.8-14.6).

Time from illness onset to death

In an analysis of published data, Linton (J Clin Med 2020, see ***below***) found a median time delay of 13 days from illness onset to death (17 days with right truncation).

Case fatality rate

Case fatality rate in China

Early data from China yielded an estimated mortality of the COVID-19 of approximately 2.84%, based on 1 975 infections and 56 deaths reported in 26 days since the first official announcement of the epidemic (Wang J Med Virol

2020, see ***below***). Data available by April 28 12:00 CET now point towards a higher value (83 938 confirmed cases and 4637 deaths in China, corresponding to 5.5% (Johns Hopkins University dashboard at https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6).

Obviously, this type of estimate has to be taken with a lot of caution. As indicated by Kobayashi (J Clin Med 2020, see ***below***), the observed dataset of reported cases represents only a proportion of all infected individuals and there can be a substantial number of asymptomatic and mildly infected individuals who are never diagnosed. Several authors suggested that the number of reported cases of the disease, in China as well as in other countries, is likely to be underestimated (see for instance De Salazar on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.13.20022707v1). Battegay (Swiss Med Wkly 2020, see ***below***), like Kobayashi (J Clin Med 2020, see ***below***), or Baud (Lancet Inf Dis 2020, see ***below***) also pointed to the fact that diagnosis of COVID-19 infection will precede recovery or death by days to weeks and that the number of deaths should therefore be compared to the past case counts. Lack of a standardized case definition also affects estimates of case fatality rates (see Case definition ***below***).

Other authors, like Spychalski (Lancet Infect Dis 2020, see ***below***) showed that the case fatality rate calculated per total cases seems to remain the best tool to express the fatality of the disease, even though it might underestimate this figure in the initial phase of an outbreak.

Ji, Ma et al. (Lancet 2020, see ***below***) highlighted the difference in mortality rates between Hubei and other Chinese provinces. The authors postulated that this difference is likely to be related to the rapid escalation in the number of infections around the epicentre of the outbreak, which has resulted in an insufficiency of health-care resources, thereby negatively affecting patient outcomes in Hubei, while this has not yet been the situation for the other parts of China.

A similar observation was made by Mizumoto (Em Inf Dis 2020, see ***below***), who estimated the time-delay adjusted risk for death from COVID-19 as of February 28, 2020 in China. The estimates of the risk for death in Wuhan reached values as high as 12% in the epicenter of the epidemic and ≈1% in other, more mildly affected areas. Comparable results were obtained by Wilson (Em Inf Dis 2020, see ***below***), who reported case-fatality risks, when adjusted for a 13-day lag time from reporting to death, of 3.5% in China and 0.8% in China, excluding Hubei Province.

Nevertheless, according to the large retrospective study reported by the Novel Coronavirus Pneumonia Emergency Response Epidemiology Team (Zhonghua Liu Xing Bing Xue Za Zhi 2020, see ***below***; and Wu JAMA 2020, see ***below***), based on the 72 314 reports received through February 11 2020 by the Chinese Centre for Disease Control and Prevention in mainland China, 1023 deaths were observed out of a total of 44 672 confirmed cases, corresponding to a case-fatality rate of 2.3%. This analysis also showed that the case-fatality rate is largely influenced by the age of the patients (Table 8).

Table 8 Patients, deaths, and case fatality rates, as well as observed time and mortality for n=44,672 confirmed COVID-19 cases in Mainland China as of February 11, 2020 (from The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team Zhonghua Liu Xing Bing Xue Za Zhi 2020).

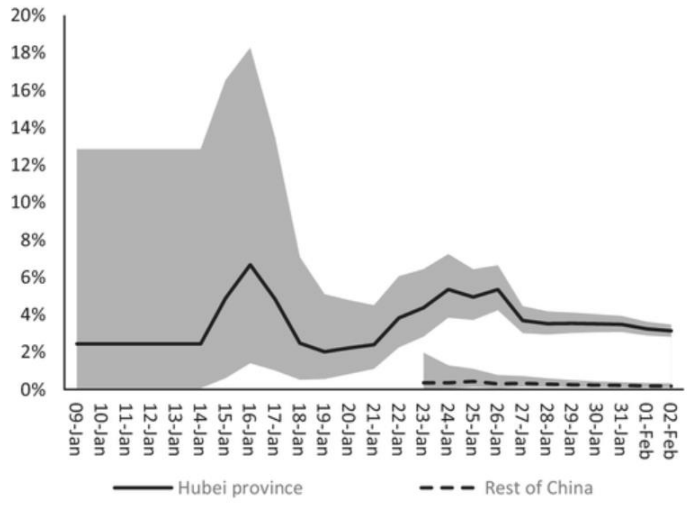
Baseline Characteristics	Confirmed Cases, N (%)	Deaths, N (%)	Case Fatality Rate, %
Overall	44,672	1,023	2.3
Age, years			
0–9	416 (0.9)	–	–
10–19	549 (1.2)	1 (0.1)	0.2
20–29	3,619 (8.1)	7 (0.7)	0.2
30–39	7,600 (17.0)	18 (1.8)	0.2
40–49	8,571 (19.2)	38 (3.7)	0.4
50–59	10,008 (22.4)	130 (12.7)	1.3
60–69	8,583 (19.2)	309 (30.2)	3.6
70–79	3,918 (8.8)	312 (30.5)	8.0
≥80	1,408 (3.2)	208 (20.3)	14.8

Of note, the WHO-China Joint Mission on Coronavirus Disease 2019 Mortality, which presented data on 2114 COVID-19 related deaths among 55 924 laboratory-confirmed cases in China, also reported the highest mortality among people over 80 years of age, with a case fatality rate of 21.9% (https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf).

A study by Wu (Nat Med 2020: https://www.nature.com/articles/s41591-020-0822-7) provided somewhat lower estimates of the case fatality rate in Wuhan, of 0.3% (0.1–0.7%), 0.5% (0.3–0.8%) and 2.6% (1.7–3.9%) for those aged <30 years, 30–59 years and >59 years, respectively.

Using a different approach, and based on early data, Wu (Eurosurv 2020, see ***below***) also estimated the risk of fatality among hospitalised cases at 14% (95% confidence interval: 3.9-32%). This estimate of the hospital fatality risk remained fairly stable over the 10-day period since the first death was announced on 11 January. Subsequently, Leung (Rev Med Vir 2020, see ***below***) calculated that as of 2 February 2020, over 17 000 cases were confirmed in China, with a hospital fatality rate of 2.1%; in Hubei province, the hospital fatality rate reached 3.1%, significantly above the rest of China (Figure 7).

Figure 7 Trends of hospital fatality rates in Hubei province and the rest of China with 95% CI (from Leung Rev Med Vir 2020)



Case fatality rate outside China

Wilson (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.15.20023499v1) considered symptomatic cases outside of China (countries/settings with 20+ cases) and the proportion who are in intensive care units (4.0%, 14/349 on 13 February 2020). Given what is known about case fatality rates for intensive care unit patients with severe respiratory conditions from a meta-analysis, he estimated a case fatality rate of 1.37% (95%CI: 0.57% to 3.22%) for COVID-19 cases outside of China.

Using data as of as of March 5 2020, Wilson (Em Inf Dis 2020, see ***below***) also reported a case fatality estimate in 82 countries, territories, and areas reaching 4.2%.

Rajgor (Lancet Inf Dis 2020, see ***below***) acknowledged the level of variability of COVID-19 case fatality rate estimates, and noted that a unique situation has arisen for estimating the case fatality rate with the outbreak onboard the Diamond Princess cruise ship. This scenario provided a population living in a defined territory without most other confounders, such as imported cases, defaulters of screening, or lack of testing capability. 3711 passengers and crew were onboard, of whom 705 became sick and tested positive for COVID-19 and seven died, giving a case fatality rate of 0.99%. If the passengers onboard were generally of an older age, the case fatality rate in a healthy, younger population could be lower.

The systematic review of COVID-19 epidemiology by Park (J Clin Med 2020, see ***below***), which included 41 studies, indicated that current model-based estimates ranged from 0.3% to 1.4% for outside China.

Italy

Based on the first 888 cases confirmed in Italy, Porcheddu (J Infect Dev Ctries 2020, see ***below***) noted that the case fatality rate in China and Italy were identical at 2.3%. Livingston (JAMA 2020, see ***below***) provided a case fatality rate per age group in Italy. It was found to increase with age, up to 22.7% in subjects 90 years of age and older. A subsequent report by Onder (JAMA 2020, see ***below***) mentioned an overall fatality rate of persons with confirmed COVID-19 of 7.2% (calculated as number of deaths/number of cases), and a case fatality rate of 20.2% in subjects >80 years of age.

Onder (JAMA 2020, see ***below***) mentioned an overall fatality rate of persons with confirmed COVID-19 of 7.2% (calculated as number of deaths/number of cases), and a case fatality rate of 20.2% in subjects >80 years of age in Italy. Deaths were said to be mainly observed among older, male patients with multiple comorbidities. However, the data presented by Onder remained limited, and derived from the first month of documented COVID-19 cases in Italy.

Subsequently, Barone-Adesi (Disaster Med Public Health Prep 2020, see ***below***) commented on the higher case-fatality rate observed in Italy compared to China, and suggested that the Italian testing strategy could explain an important part of the observed difference. The majority of patients that are currently tested in Italy have severe clinical symptoms that usually require hospitalization. Indeed, the proportion of positive cases that are admitted to the hospital in Italy is about 40% (and used to be much higher in previous weeks), while it was about 10-20% in China. As the positive cases resulting from this testing strategy are so skewed towards more serious conditions, it is not surprising that a higher case fatality rate is observed.

Another study rejected the possibility that social habits and intergenerational contacts contribute to explain the number of deaths observed in Italy (Giangreco J Trav Med 2020, see ***below***)

U.S.A.

Preliminary reports from 4226 patients with COVID-19 in the United States indicated that fatality was highest in persons aged ≥85, ranging from 10% to 27%, followed by 3% to 11% among persons aged 65–84 years, 1% to 3% among persons aged 55-64 years, <1% among persons aged 20–54 years, and no fatalities among persons aged ≤19 years (CDC COVID-19 Response Team MMWR Morb Mortal Wkly Rep 2020, see ***below***).

McMichael (NEJM 2020, see ***below***) described an outbreak linked to a long-term care facility in the U.S. (Washington state). Case-fatality rate among residents (median age 83 years, ranging from 51 to 100) reached 35%.

Special populations

Elderly

In the study reported by Chen (Lancet 2020, see ***below***), COVID-19 was found more likely to affect older males with comorbidities. The impact of age as well as gender and comorbidities is described in the section ***At risk populations***.

Haemodialysis patients

A manuscript by Ma depicted 37 cases of disease in a cohort of 230 haemodialysis patients in Wuhan (https://www.medrxiv.org/content/10.1101/2020.02.24.20027201v2.full.pdf). Despite the death of 6 patients with COVID-19 vs. 1 without COVID-19 during the study, the symptoms reported for most of the patients were mild, and there were no cases admitted to ICU.

Cancer patients

Data are available to show that cancer patients seem to be at increased risk of COVID-19 and increased risk of severe events (see section ***At risk populations***).

Immunocompromised patients

Minotti (J Inf 2020, see ***below***) identified 16 publications with 110 immunosuppressed patients, mostly presenting cancer, along with transplantation and immunodeficiency. Cancer was more often associated with a more severe course, but not necessarily with a bad prognosis. The data showed that both children and adults with immunosuppression seemed to have a favourable disease course, as compared to the general population. The authors indicated that this observation might be explained by a hypothetical protective role of a weaker immune response, determining a milder disease presentation and thus underdiagnosis. Nevertheless, surveillance on this special population remains to be encouraged.

Primary Antibody Deficiencies patients

Quinti (J Allergy Clin Immunol 2020, see ***below***) identified seven Primary Antibody Deficiencies (PAD) patients with COVID-19 infection: five affected with Common Variable Immune Deficiencies (CVIDs) and two affected with Agammaglobulinemia, one with X-linked Agammaglobulinemia (XLA) and one with Autosomal Recessive Agammaglobulinemia (ARA). All PAD patients have defective antibody production. Patients with Agammaglobulinemia lack B lymphocytes whereas patients with Common Variable Immune Deficiency have dysfunctional B lymphocytes. In patients affected with agammaglobulinemias, the COVID-19 course was characterized by mild symptoms, short duration, with no need of treatment with the immune-modulating drug blocking IL-6, and had a favourable outcome. In contrast, patients affected with Common Variable Immune Deficiencies presented with a severe form of the disease requiring multiple drug treatment, including antiretrovirals agents and IL-6 blocking drugs, and mechanical ventilation. The strikingly different clinical course of COVID-19 in patients with agammaglobulinemia compared to CVIDs cannot be explained by the level of serum immunoglobulins which were similarly low in all PAD patients at diagnosis.

Children

Paediatric data from China

The first confirmed paediatric case of SARS-CoV-2 infection is said to have been reported in Shenzhen on January 20 (Cao J Formos Med Assoc 2020, see ***below***). By January 30, there were 28 children (1 month to 17 years) with confirmed infection in China (Shen World J Pediatr 2020, see ***below***). The clinical features appeared variable. Several patients displayed no obvious clinical symptoms at diagnosis, and they were found by screening because of close contacts with confirmed patients; and further chest imaging suggested pneumonia. Several gradually presented with fever, fatigue, dry cough, accompanied by other upper respiratory symptoms including nasal congestion, runny nose, and seldom

gastrointestinal symptoms such as nausea, vomiting and diarrhoea. Laboratory examination in paediatric patients showed that blood routine was often normal, and C-reactive protein was normal or transiently elevated. Lung imaging examination revealed mild increase of lung markings or ground-glass opacity or pneumonia. Most paediatric patients had mild symptoms, without fever or pneumonia. They had good prognosis and recovered within 1-2 weeks after disease onset. Only a few patients had lower respiratory tract infections. No severe cases or deaths have been reported in the paediatric population up to now.

With the progression of the outbreak, the first infant case was reported from Xiaogan, Hubei province. This was a 3-month-old female infant who had fever for one day and as discharged uneventfully 2 weeks later (Cao J Formos Med Assoc 2020, see ***below***). A subsequent retrospective study described 9 cases in children (7 females/2 males) aged 1 to 11 months (Wei JAMA 2020, see ***below***). Four patients were reported to have fever, 2 had mild upper respiratory tract symptoms, 1 had no symptoms but tested positive for COVID-19 in a designated screening because of exposure to infected family members, and 2 had no information on symptoms available. None of the 9 infants required intensive care or mechanical ventilation or had any severe complications.

Liu (NEJM 2020, see ***below***) retrospectively reported 6 paediatric cases treated in Wuhan hospitals in January 2020. One of the 6 children was admitted to the paediatric intensive care unit. All the patients recovered after hospitalization for a median of 7.5 days (range, 5 to 13).

Xia (Pedriatr Pulmonol 2020, see ***below***) presented the clinical, laboratory, and chest CT features of 20 paediatric inpatients with COVID-19 in Wuhan. Fever (12/20, 60%) and cough (13/20, 65%) were the most common symptoms. Procalcitonin elevation was found frequently (16/20, 80%).

A case in a 55 day-old infant was reported in detail by Cui (J Infect Dis 2020, see ***below***). The patient initially presented with mild dry cough and no fevers. However, symptoms became gradually worse from day 7 to day 11 of illness, and symptomatic support was strengthened. This case highlighted that infants with COVID-19 can also present with multiple organ damage and rapid disease changes.

The retrospective Chinese study involving COVID-19 cases reported through February 11, 2020, and corresponding to 44672 confirmed cases, 549 cases were identified in the 10-19 years age group (1%) and 416 cases among children less than 10 years (1%) (Wu JAMA 2020, see ***below***).

Lu (NEJM 2020, see ***below***) tested 1391 children from January 28 through February 26, 2020 in Wuhan, of whom a total of 171 (12.3%) were confirmed to have SARS-CoV-2 infection. The median age of the infected children was 6.7 years. Fever was detected in 41.5%. Other common signs and symptoms included cough and pharyngeal erythema. A total of 27 patients (15.8%) did not have any symptoms of infection or radiologic features of pneumonia. A total of 12 patients had radiologic features of pneumonia but did not have any symptoms of infection. During the course of hospitalization, 3 patients required intensive care support and invasive mechanical ventilation; all had coexisting conditions (hydronephrosis, leukemia, and intussusception). Lymphopenia was present in 6 patients (3.5%). The most common radiologic finding was bilateral ground-glass opacity (32.7%). As of March 8, 2020, there was one death: a 10-month-old child with intussusception had multiorgan failure and died 4 weeks after admission.

Another large paediatric cohort in China was reported by Dong (Pediatrics 2020, see ***below***). There were 731 (34.1%) laboratory-confirmed cases and 1412 (65.9%) suspected cases. The median age of all patients was 7 years (interquartile range: 2-13). Over 90% of all patients were asymptomatic, mild, or moderate cases.

From a systematic review of COVID-19 in children, Ludvigsson (Acta Paediatr 2020, see ***below***) identified 45 relevant scientific papers and letters describing mostly paediatric cases from China. The data showed that children have so far accounted for 1-5% of diagnosed COVID-19 cases, that they often have milder disease than adults and deaths have been extremely rare. Diagnostic findings have been similar to adults, with fever and respiratory symptoms being

prevalent, but fewer children seem to have developed severe pneumonia. Elevated inflammatory markers were less common in children and lymphocytopenia seemed rare.

Paediatric data from other countries

In Singapore, there were 3 confirmed cases reported, who were very young (aged 6 months, 1 year, and 2 years) and had very mild symptoms (Wong JAMA 2020, see ***below***).

Park (J Korean Med Sci 2020, see ***below***) reported the first paediatric case of COVID-19 in Korea, a 10-year-old girl who presented mild clinical course of her pneumonia that did not require antiviral treatment.

Systematic reviews and meta-analyses

A systematic review by Castagnoli (JAMA Pediatr 2020, see ***below***) identified seventeen studies conducted in China and one in Singapore, including a total of 1065 paediatric cases of SARS-CoV-2 infection. Data from this review showed that most children and adolescents who were infected by SARS-CoV-2 (i.e., tested positive by nasopharyngeal swab) presented with mild symptoms. Frequent clinical manifestations included fever, dry cough, and fatigue accompanied by other upper respiratory symptoms, such as nasal congestion and runny nose. Moreover, the main gastrointestinal symptoms were nausea, vomiting, and diarrhoea, which were reported in a few cases, particularly in a newborn and infants. In this analysis, only one paediatric case presented with severe lower respiratory tract infection (COVID-19 pneumonia), complicated by shock and kidney failure, and fortunately, it was successfully treated with intensive care.

The review by Hasan (Cureus 2020, see ***below***) provided a summary of laboratory and clinical imaging data in children.

Risk of infection in children

While the disease seems to have a milder course in children than adults, a manuscript by Qifang Bi on MedRxiv (https://www.medrxiv.org/content/10.1101/2020.03.03.20028423v1) suggested that children are at a similar risk of infection as the general population. This conclusion was driven from 391 cases and 1286 close contacts identified by the Shenzhen CDC. However, other lines of evidence pointed to a different attack rate of the disease in children compared to adults. In Iceland, Gudbjartsson (NEJM 2020, see ***below***), carried out both targeted testing of persons at high risk for infection and population screening by RT-PCR. Children under 10 years of age were less likely to be found positive than were persons 10 years of age or older (6.7% vs. 13.7% for targeted testing; 0% vs. 0.8% in the population screening). In China, a household cohort study found a secondary attack rate in children of 4% comparing with 17.1% in adults (Li, Zhang et al. Clin Inf Dis 2020, see ***below***).

Pregnancy and newborns

In general, pregnancy is a physiological state in which women are more susceptible to respiratory pathogens and severe pneumonia, due to an immunosuppressive state and various physiological adaptive changes (e.g., diaphragm elevation, increased oxygen consumption, and oedema of respiratory tract mucosa). It is therefore reasonable to predict that pregnant women might be at greater risk for severe illness. Previous epidemics of other strains of CoV, such as SARS-CoV and MERS-CoV, have typically resulted in severe complications during pregnancy such as maternal morbidity and mortality, perinatal infections and death (Wong Am J Obstet Gynecol 2004, see ***below***; and Alfaraj J Microbiol Immunol Infect 2019, see ***below***). Analysis of the literature up till now reveals that, unlike CoV infections of pregnant women caused by SARS and MERS, pregnant women are not more susceptible to COVID-19, nor are they at risk of more severe disease than the non-pregnant population. Until recently, there was no evidence of vertical transmission of COVID-19 from the mother to the foetus. However, emerging evidence now suggests that vertical transmission might be possible.

We acknowledge that available clinical data on COVID-19 infection in pregnancy are limited at present, and most cases on which data are available presented in the third trimester of pregnancy. There is, therefore, a need to continue collecting data on clinical cases of COVID-19 infection in pregnancy, and to improve our understanding of the course of the disease throughout pregnancy.

Clinical characteristics of the pregnant woman with COVID-19 infection

Multiple studies have observed the clinical characteristics of COVID-19 pneumonia in pregnant women. Most data stem from case reports and small case series[3]. Recently, a higher level of evidence has been obtained from the reporting of a case-control study by Li (Clin Inf Dis 2020, see ***below***) and a systematic review of 108 pregnancies by Zaigham (Acta Obstet Gynecol Scand 2020, see ***below***).

An earlier retrospective study in 9 pregnant women who had a caesarean section in their third trimester had not shown any severe COVID-19 pneumonia or maternal death (Chen, Guo et al. Lancet 2020, see ***below***). The clinical characteristics of COVID-19 pneumonia in pregnant women seemed to be similar to those reported for non-pregnant adults with the disease. Li (Clin Inf Dis 2020, see ***below***) found that, compared to other COVID-19 pneumonia patients, pregnant women generally had no or mild respiratory symptoms, with fever being the predominant presenting symptom. Similarly, Zaigham (Acta Obstet Gynecol Scand 2020, see ***below***) described fever at admission in 68% of patients. A persistent, dry cough (34%) along with malaise (13%) and dyspnea (12%) were less commonly described.

Various centres are now screening patients for COVID-19, even in the absence of symptoms. More reports on asymptomatic COVID-19 infected pregnant women are now emerging. Chen, Liao et al. (J Med Virol 2020, see ***below***) reported that COVID-19 could asymptomatically occur during gestation, but get diagnosed after delivery. This finding highlights the necessity of appropriate screening and protection measures. Breslin (Am J Obstetrics & Gynecology MFM 2020, see ***below***) also highlighted this finding in a case-study of 43 test-confirmed cases of COVID-19. They reported asymptomatic women with COVID-19 infection, of whom the majority subsequently developed temperature elevations or disease symptoms. Another study by Sutton (NEJM 2020, see ***below***) described 33 pregnant women who tested positive for COVID-19, of whom 29 (87,9%) showed no symptoms of the disease. The authors recommended universal testing for all pregnant women admitted to the labour unit.

Perinatal complications

Pregnancy may not increase susceptibility to COVID-19 infection or influence the severity of the disease, but COVID-19 infection does seem to influence the pregnancy. Severe pneumonia during pregnancy (regardless of the causative agent) increases the risk of preterm delivery, foetal growth restriction, low birth weight and low Apgar score at birth.

Regarding perinatal outcomes, most authors do not report adverse events (Chen Guo Lancet 2020, see ***below***; Zhang Zhonghua Fu Chan Ke Za Zhi 2020, see ***below***; Wang Clin Inf Dis 2020, see ***below***; Yu Lancet Inf Dis 2020, see ***below***; Liu AJR Am J Roentgenol 2020, see ***below***; Wang Guo Clin Inf Dis 2020, see ***below***). However, Zhu (Transl Ped 2020, see ***below***) presented the clinical features and outcomes of ten neonates, born to mothers with confirmed 2019-nCoV infection. One newborn died from multiple organ failure and disseminated intravascular coagulation (DIC), and another had DIC but recovered. Six out of ten neonates were born preterm. None of the neonates tested positive for SARS-CoV-2. The first meta-analysis on pregnancy outcome found preterm birth to be the most common adverse pregnancy outcome (Di Mascio Am J Obst & Gynecol MFM 2020, see ***below***). Li (Clin Inf Dis 2020, see ***below***) found a higher incidence rate of premature delivery in confirmed cases (18,8%) compared to the two control groups (5%), but none was due to severe maternal respiratory failure. All these events of preterm delivery were triggered by gestational complications such as premature rupture of membranes and placental bleeding, which might not be directly related to COVID-19 pneumonia.

Regarding maternal conditions, we note that COVID-19 infection in pregnancy seems to be less severe than other coronavirus infections. The proportion of women requiring ICU admission seems to be similar to that reports in the general population and is highly correlated with comorbidity. Two studies reported a total of three cases of maternal ICU admission (Breslin Am J Obst & Gynecol MFM 2020:

[3] See for instance Chen Guo Lancet 2020; Liu, Chen J Inf 2020; Zhang Zhonghua Fu Chan Ke Za Zhi 2020; Chen Huang Zhonghua Bing Li Xue Za Zhi 2020; Fan Clin Inf Dis 2020; Wang Clin Inf Dis 2020; Li Clin Inf Dis 2020; Yu Lancet Inf Dis 2020

https://www.sciencedirect.com/science/article/pii/S2589933320300410; Alzamora Am J Perinatol 2020; see ***below***). All mothers had obesity class II or more and type 2 diabetes mellitus. Liu (J Inf 2020, see ***below***) reported one pregnancy where multiple organ dysfunction syndrome (MODS) with acute respiratory distress syndrome (ARDS) led to an emergency caesarean section. The neonate was stillborn and the mother required extracorporeal membrane oxygenation (ECMO). Regrettably, the first report of maternal death with confirmed COVID-19 infection was reported (Karami Travel Med Infect Dis 2020, see ***below***). A woman of 30 weeks of gestation presented with fever, myalgia and cough for three days. A rapid deterioration in clinical and imaging findings occurred within 30 hours. The patient delivered a cyanotic foetus with an Apgar score of 0 and passed away due to development of multi-organ failure. Considering the multi-organ failure, the definite cause of death could not be identified.

Hence, evidence is building that perinatal COVID-19 infection may have adverse effects on neonate and mother. Though less serious than SARS-CoV, in which adverse outcomes were reported in 10 out of 12 pregnancies, COVID-19 pregnancy seems not to be without risk. COVID-19 infection has been shown to be associated with a cytokine-storm (Huang Lancet 2020, see ***below***). It is known that pregnancy is associated with a proinflammatory state in first and third trimester. Based on this knowledge, the cytokine storm induced by SARS-CoV-2 may induce a more sever inflammatory state in these women. Abnormally elevated levels of TNF-α in maternal peripheral blood can be toxic to early embryo development and have been shown to induce preterm labour in non-human primate models (Yockey Immunity 2018, see ***below***). Furthermore, maternal inflammation as a result of viral infection during pregnancy can affect several aspects of foetal brain development and may lead to a wide range of neuronal and behavioural dysfunctions in postnatal life (Mor Nat Rev Immunol 2017, see ***below***) Therefore, although current observations do not find detectable COVID-19 infection in the foetus, it is necessary to pay close attention to the potential risks of maternal viral infection on the foetus.

Vertical transmission

Current evidence suggests that there is no evidence of vertical transmission of COVID-19. Repetitive negative samples of amniotic fluid, cord blood, neonatal throat swabs, placental tissue, genital fluid and breastmilk samples from COVID-19 infected mothers are reported in multiple studies (Chen Guo Lancet 2020, see ***below***; Chen Huang Zhonghua Bing Li Xue Za Zhi 202; Yu Lancet Inf Dis 2020, see ***below***; Wang Guo Clin Inf Dis 2020, see ***below***; Zhu Transl Ped 2020, see below; Yang Ultrasound Obstet Gynecol 2020, see ***below***; Khan Inf Contr Hosp Epi 2020, see ***below***; Liu Front Med 2020, see ***below***). However, emerging studies are now implying that vertical transmission may occur, although the proportion of pregnancies affected and the significance to the neonate has yet to be determined.

A cohort study by Zeng (JAMA Pediatr 2020, see ***below***) described 33 neonates born to mothers infected with COVID-19. Of these 33 neonates, 3 (9%) showed positive nasopharyngeal swabs on day 2 of life. Though strict infection control and prevention measures were implemented during the delivery, one cannot completely exclude postpartum infections because of the delay in testing. Zhang (Eur Respir J 2020, see ***below***) described three cases of COVID-19 positive neonates delivered through caesarean section and under level III protection. No mother-child contact or breastfeeding had occurred. Alzamora (Am J Perinatol 2020; see ***below***) reported a case of a newborn who tested positive on RT-PCR of nasopharyngeal swab as soon as 16 hours after delivery. As in the cases mentioned above, there was a low probability of infection during the caesarean section or postnatally, due to sterility of the procedure and isolation measures implemented immediately after birth. Taken together, these findings strongly raise the suspicion of *in utero* transmission of SARS-CoV-2.

Furthermore, two articles from separate research teams in China presented details of 3 neonates who may have been infected with COVID-19 *in utero* from infected mothers (Zeng JAMA 2020, see ***below***; Dong JAMA 2020, see ***below***). The authors found elevated IgM and IgG antibody titers in blood drawn from the neonates following birth. No infant had a positive qRT-PCR, so there was no virologic evidence for congenital infection. IgG is passively transferred across the placenta from mother to foetus. By contrast, IgM is too large to cross the placenta, thus IgM must have been produced by the infant when the virus crossed the placenta. However, IgM assays can be prone to false-positive results,

along with cross-reactivity and testing challenges (Wang J Clin Microb 2020, see ***below***). Additionally, the kinetics of decline of IgM detailed in the study by Dong are unusual compared with rates of decline in other congenitally transmitted infections. The neonate's IgM value declined from 45.83 AU/mL at 2 hours of life to 11.75 AU/mL on day 14 of life, just above the threshold of 10 AU/mL that constitutes a positive result. Alzamora (Am J Perinatol 2020; see ***below***) also evaluated neonatal immunoglobulins in a SARS-CoV-2 positive neonate. The authors reported negative serology in both mother and neonate on the day of birth, with seroconversion of the mother on day 5. In contrast, neonatal serology remained negative. This could be explained by the immaturity of the adaptive immunity in the neonatal period. The challenges with false-positive IgM test results, along with a rapid decline in IgM concentration and the fact that an immature immune system in the neonatal period may not be capable of developing IgMs, raises the possibility that the laboratory findings in the 3 infants in the first case reports are not evidence of true congenital infection but rather could represent artifact.

Zeng (Reprod Dev Med 2020: http://www.repdevmed.org/preprintarticle.asp?id=278679) described a very low expression of ACE2 in almost all human cell types of the early maternal-foetal interface, suggesting the placenta had virtually no susceptible cells to the virus. In contrast, Li, Chen et al. (PLoS One 2020, see ***below***) evaluated cell specific expression of ACE2 at the maternal-foetal interface as well as in multiple foetal organs. The authors found a high expression of ACE2 in maternal-foetal cells (stromal cells, perivascular cells of decidua, cytotropho- and syncitiotrophoblast in placenta). ACE2 expression was also found in specific cell types of human fetal heart, liver and lung, but not in kidney. Moreover, they observed a dynamic change in ACE2 expression over time in a study containing series fetal and post-natal mouse lung. ACE2 was extremely high in neonatal mice at post-natal day one to three. They conclude that both the vertical transmission and the placenta dysfunction/abortion caused by SARS-CoV-2 needs to be further carefully investigated in clinical practice.

All studies above described pregnancies in their third trimester, therefore the time interval from clinical manifestation of COVID-19 infection to delivery was short. The placental barrier is capable of delaying the transfer of the virus from mother to foetus; therefore, it remains uncertain whether there could be a risk of vertical transmission when the COVID-19 infection occurs earlier in the pregnancy. The first study on SARS-CoV-2 infected pregnant women in early pregnancy was recently reported (Yu Lancet Inf Dis 2020, see ***below***). Two pregnant women were diagnosed with COVID-19 in the first trimester of pregnancy. In the second trimester, both patients tested positive for SARS-CoV-2 total antibodies in serum, while nasopharyngeal swabs were negative. The results of RT-PCR tests of the patients' amniotic fluid were negative, and tests for SARS-CoV-2 IgM and IgG in amniotic fluid were also negative. However, RNA is much less stable in amniotic fluid than is DNA and the virus might have been undetectable in amniotic fluid because of insufficient gestational age. Therefore, although SARS-CoV-2 was not detected in the amniotic fluid, the possibility of vertical transmission could not be ruled out.

Intrapartum / post-partum infections

It is hypothesized that neonates acquire the infection during delivery or post-partum. A study by Fan (Clin Inf Dis 2020, see ***below***) did explore the topic of intrapartum transmission by testing vaginal secretions of COVID-19 infected mothers. They found vaginal swabs to be negative in all cases. Another study examined the presence of SARS-CoV-2 in vaginal fluids of patients with severe COVID-19 infections. In accordance with Fan et al., all samples were negative (Qiu Clin Infect Dis 2020, see ***below***). These findings may indicate that vaginal delivery does not increase the risk of viral transmission. A subsequent case report by Khan (Inf Contr Hosp Epi 2020, see ***below***) also added evidence to suggest that the risk of vertical transmission during vaginal delivery might be trivial. Three COVID-19 infected women delivered three healthy babies through vaginal delivery. None of the newborns tested positive 12 hours after birth. The CDC therefore states that COVID-19 infection is not an indication for delivery and that vaginal delivery can be pursued in the event of spontaneous labour and good maternal condition. Effective implementation of protection measures during delivery, such as negative-pressure delivery room and shortening of the second stage, may help prevent the infant from acquiring COVID-19.

Due to possible post-partum transmission of the disease, there has been discussion on whether or not to separate mother and newborn. Consensus guidance from China recommends routine separation of neonates from mothers infected by COVID-19 for at least 14 days (Chen Int J Gyn Obstetr 2020, see ***below***). During this period, direct breastfeeding is not recommended. However, routine precautionary separation of a mother and a healthy baby should not be undertaken lightly, given the potential detrimental effects on feeding and bonding. Furthermore, breastmilk contains specific antibodies with the capability of modulating an eventual SARS-CoV-2 infection in the newborn. Therefore, the Royal College of Obstetricians and Gynaecologists in the U.K. advises against routine separation of mother and baby and provides guidance on individualized care (https://www.rcog.org.uk/globalassets/documents/guidelines/2020-03-28-covid19-pregnancy-guidance.pdf) and the WHO states that women with COVID-19 can breastfeed if they wish to do so, with respect for respiratory and hand hygiene.

Case definition

Interim case definitions based on the current information available have been issued by WHO (https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov)). The latest version of the document is dated March 20. These might be revised as new information accumulates, or can be adapted by countries depending on their own epidemiologic situation. The case definition currently used in China for instance can be found in the seventh edition (3 March 2020) of the guideline (Wang Mil Med Res 2020, see ***below***).

Suspect case

A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset; OR

B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset; OR

C. A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

Probable case: A. A suspect case for whom testing for SARS-CoV-2 is inconclusive[4] or B. A suspect case for whom testing could not be performed for any reason

Confirmed case

A person with laboratory confirmation of SARS-CoV-2 infection, irrespective of clinical signs and symptoms.

In view of the clinical disease characteristics reported in the literature (and in particular the publication by Guan in NEJM reporting only 43.8% of patients presenting with fever on admission), Zavascki (NEJM 2020, see ***below***) noted that the current COVID-19 suspect case definition of WHO may lead to underdiagnosis.

Definition of severe disease

While WHO has not provided a definition of severe cases of COVID-19, various publications have classified disease cases according to severity. For instance, Zhang (Allergy 2020, see ***below***) designated severe COVID-19 when the patients had one of the following criteria: 1) Respiratory distress with respiratory frequency ≥ 30/min; 2) Pulse Oximeter Oxygen Saturation ≤ 93% at rest; 3) Oxygenation index (artery partial pressure of oxygen/inspired oxygen

[4] *Inconclusive being the result of the test reported by the laboratory*

fraction, PaO2/FiO2) ≤ 300 mmHg. Critical cases have also been defined as having respiratory failure, septic shock, and/or multiple organ dysfunction or failure (with fatal cases reported only in the last group) (Wu JAMA 2020, see ***below***).

Pathophysiology of COVID-19

The pathogenesis of COVID-19 is under investigation. Of note, a review on the comparative pathogenicity of the different human coronaviruses was published by Liu (J Med Vir 2020, see ***below***).

Viral tropism

The S protein is responsible for coronavirus entry into the cell after by binding to a cell receptor and membrane fusion, two key steps in viral infection and pathogenesis (Benvenuto J Med Vir 2020, see ***below***). Virus infectivity studies using HeLa cells expressing or not expressing ACE2 proteins from humans, Chinese horseshoe bats, civet, pig, and mouse showed that SARS-CoV-2 is able to use all but mouse ACE2 as an entry receptor in ACE2-expressing cells, but not cells without ACE2. ACE2 therefore appears as the likely cell receptor of SARS-CoV-2 (Zhou Nature 2020, see ***below***). It was also demonstrated that SARS-CoV-2 does not use other coronavirus receptors, aminopeptidase N and dipeptidyl peptidase 4.

However, cell entry of coronaviruses depends not only on binding of the viral S proteins to cellular receptors but also on S protein priming by host cell proteases. Koffmann (Cell 2020, see *Error! Reference source not found.*) demonstrated t hat SARS-CoV-2 uses the SARS-CoV receptor ACE2 for entry and the serine protease TMPRSS2 for S protein priming.

ACE2 is expressed in a variety of cells of different organs (endothelium, liver, lungs, etc.) and is part of the renin-angiotensin blood pressure regulation system. In the respiratory tract, it is expressed on the apical face of respiratory epithelial cells via which infection may be mediated. Along the respiratory tract, ACE2 has been detected in the trachea, main bronchus and alveoli, and occasionally also in the small bronchi. An expression study found that ACE2 was mostly (83%) expressed by type II alveolar cells (AT2), and that this cell population also highly expressed other genes that positively regulate viral reproduction and transmission (Zhao on Biorxiv: https://www.biorxiv.org/content/10.1101/2020.01.26.919985v1).

By single cell sequencing, Weng (on BioRxiv https://www.biorxiv.org/content/10.1101/2020.02.08.926006v3.full.pdf) found a strong co-expression between ACE2 and TMPRSSs, especially TMPRSS1 and TMPRSS2, in lung AT2 cells, which was also the main infected cell type in SARS-CoV pneumonia. Moreover, he found the endocytosis-associated genes were highly expressed in AT2 cells, implying that endocytosis may also facilitate the entry of SARS-CoV-2 into host cells. As the alveolar stem-like cells, AT2 cells promote surfactant biosynthesis, self-renewal and immunoregulation. Thus, SARS-CoV-2 appears to not only damage the AT2 cells leading to the direct injury to alveoli, but also raise alveolar surface tension to induce dyspnoea.

Lukassen (EMBO J 2020, see ***below***) investigated virus infection in the respiratory tract. SARS-CoV-2 was reported to enter cells via binding to ACE2, followed by its priming by TMPRSS2. ACE2 was found predominantly expressed in a transient secretory cell type in the subsegmental bronchial branches. Interestingly, these transiently differentiating cells show an enrichment for pathways related to RHO GTPase function and viral processes suggesting increased vulnerability for SARS-CoV-2 infection.

Based on the public single-cell RNA-Seq datasets, Wu (https://www.medrxiv.org/content/10.1101/2020.02.11.20022228v2) found ACE2 expression in nasal epithelial cells. The size of this population of ACE2-expressing nasal epithelial cells appeared comparable with the size of the population of ACE2-expressing AT2 cells.

Using bulk RNA-seq profiles from two public databases and single-cell transcriptomes from an independent dataset generated in-house, Xu (Nature 2020, see ***below***) found evidence of ACE2 expression in the oral cavity and suggested enrichment in epithelial cells. Moreover, among different oral sites, ACE2 expression was found higher in tongue than buccal and gingival tissues.

ACE2 and TMPRSSs are also highly co-expressed in absorptive enterocytes and upper epithelial cells of oesophagus, implying that intestinal epithelium and oesophagus epithelium may also be the potential target tissues. Liang (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.03.20020289v2) also reported that ACE2 mRNA was highly expressed in the healthy human small intestine. Besides, single-cell RNA sequencing data showed ACE2 to be significantly elevated in proximal and distal enterocytes.

In addition, a manuscript by Lin (https://www.biorxiv.org/content/10.1101/2020.02.08.939892v1) reported the use of published kidney and bladder cell atlas data and an independent unpublished kidney single cell RNA-Seq data to evaluate ACE2 gene expressions in all cell types in healthy kidneys and bladders. Results showed the enriched expression of all subtypes of proximal tubule cells of kidney and low but detectable levels of expression in bladder epithelial cells. The data suggest that the urinary system may be a potential target for infection. Fan (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.12.20022418v1) also noted that ACE2 is highly expressed in renal tubular cells, Leydig cells and cells in seminiferous ducts in testis. He recommended renal function evaluation and special care of patients, especially in case of therapy with drugs associated with renal toxicity, and suggested that clinicians should pay attention to the risk of testicular lesions in patients. However, this hypothesis is not supported by the observations by Wang (see Clinical disease in China ***above***).

Liu (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.28.20029181v1), using public datasets (bulk RNA-seq and single-cell RNA-seq), showed expression of ACE2 in pancreas (in both exocrine glands and islets), and related this observation to clinical data suggesting mild pancreatitis in some patients. Among 67 severe cases, 11 patients (16.41%) showed elevated levels of both amylase and lipase, and 5 patients (7.46%) showed imaging alterations.

To construct a risk map of different human organs, Zou (Front Med 2020, see ***below***) analysed the single-cell RNA sequencing (scRNA-seq) datasets derived from major human physiological systems, including the respiratory, cardiovascular, digestive, and urinary systems, for ACE2 expression. Through scRNA-seq data analyses, the authors identified the organs at risk, such as lung, heart, oesophagus, kidney, bladder, and ileum, and located specific cell types (i.e., type II alveolar cells (AT2), myocardial cells, proximal tubule cells of the kidney, ileum and oesophagus epithelial cells, and bladder urothelial cells) as vulnerable to SARS-CoV-2 infection.

Chen (manuscript available on Preprints: https://www.preprints.org/manuscript/202002.0258/v2) found that ACE2 expression in the lung increases with age. A high viral load in elderly patients could therefore be associated not only with low immunity but also with high expression of the ACE2 receptor. This could explain the high degree of severe disease in older patients with SARS-CoV-2 (Chen, Li Lancet Inf Dis 2020, see ***below***).

Considering that a conserved RGD (403–405:Arg-Gly-Asp) motif is present in the receptor -binding domain of the spike proteins of all SARS-CoV-2, Sigrist (Antivir Res 2020, see ***below***) presented the hypothesis that SARS-CoV-2 acquired integrin-binding to promote virus entry into host cells. However, experimental proof of this is required. Binding to integrin may play a supplemental role to ACE2 binding, like facilitating endocytosis by signalling through the integrin. Alternatively, the virus could infect different target cells by binding to ACE2 or to integrins.

Using SARS-CoV-2 S protein pseudovirus system, Ou (Nature Comm 2020, see ***below***) confirmed that human ACE2 is the receptor for SARS-CoV-2, found that SARS-CoV-2 enters 293/hACE2 cells mainly through endocytosis, and that PIKfyve, TPC2, and cathepsin L are critical for entry.

Of note, a review by Li (Pharmacol Res 2020, see ***below***) provided an interesting summary on ACE2 expression. It presents for instance the influence of sex hormones, age, or diet on expression.

Portal of entry

Xu (J Dent Res 2020, see ***below***) analysed the expression of ACE2 in human organs in the GTEx portal. The expression of ACE2 in minor salivary glands was higher than that in lungs, which suggests salivary glands could be potential target for COVID-19. In addition, SARS-CoV RNA has been detected in saliva before lung lesions appeared. A similar phenomenon could explain the presence of asymptomatic infections with COVID-19.

Determinants of pathogenicity

While information pertaining to the replication of SARS-CoV-2, and the interactions between the virus and its host, is accumulating, available data to document the mechanisms involved during infection by other human CoVs may also be of use (see for instance, Fung Ann Rev Microbiol 2019 ***below*** or Chen J Med Virol 2020 ***below***).

S protein and interaction with ACE2

The expression level and expression pattern of human ACE2 in different tissues might be critical for the susceptibility, symptoms, and outcome of SARS-CoV-2 infection. A single-cell RNA-sequencing (RNA-seq) analysis indicated that Asian males may have higher expression of ACE2. Cao (Cell Discov 2020, see ***below***) analysed coding-region variants in ACE2 and the expression quantitative trait loci (eQTLs) variants, which may affect the expression of ACE2, to compare the genomic characteristics of ACE2 among different populations. No direct evidence was identified genetically supporting the existence of S-protein binding-resistant ACE2 mutants in different populations. However, East Asian populations were found to have higher allele frequencies in the eQTL variants, associated with higher ACE2 expression in tissues, which may suggest different susceptibility or response to SARS-CoV-2 from different populations under similar conditions.

Subsequently, Hussain (J Med Vir 2020, see ***below***) found that ACE2 alleles, rs73635825 (S19P) and rs143936283 (E329G) showed noticeable variations in their intermolecular interactions with the viral S protein. These data provide a structural basis of potential resistance against SARS-CoV-2 infection driven by ACE2 allelic variants.

A manuscript by Meng (on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.02.08.926006v3.full.pdf) suggests enhanced S protein cleavage with SARS-CoV-2 compared to SARS-CoV. A SPRR insertion in the S1/S2 protease cleavage sites of SARS-CoV-2 S protein was found to increase cleavage efficiency as assessed by protein sequence alignment and furin score calculation. Additionally, the insertion sequence facilitates the formation of an extended loop which was more suitable for protease recognition by homology modelling and molecular docking. Coutard (Antivir Res 2020, see ***below***) and Wang (Virol Sin 2020, see ***below***) also identified a peculiar furin-like cleavage site in the S protein of SARS-CoV-2, which is lacking in the other SARS-like CoVs. The authors hypothesised that this cleavage site may affect the viral cycle and pathogenicity. Andersen (Nature Med 2020, see ***below***) further noted that the functional consequence of the polybasic cleavage site in SARS-CoV-2 remains unknown, and that it will be important to determine its impact on transmissibility and pathogenesis in animal models.

Through plaque purification of Vero-E6 cultured SARS-CoV-2, Lau (Em Micr Inf 2020, see ***below***) found a virus variant with in-frame deletions in the S1/S2 cleavage site region (Del-mut-1), which is attenuated in its ability to cause disease in a SARS-CoV-2 hamster model.

Infection of immune cells

Xu (Int J Oral Sci 2020, see ***below***) found ACE2 expression in lymphocytes within the oral mucosa, and reported similar expression in various organs of the digestive system and in lung, even though the proportion of ACE2-positive lymphocytes was quite small.

Wang (Cell Mol Immunol. 2020, see ***below***) showed that SARS-CoV-2 could infect T cells (MT-2 cell line) and that infection occurred through receptor-dependent, S protein-mediated membrane fusion. A very low expression level of hACE2 was found; therefore, it is possible that a novel receptor might mediate SARS-CoV-2 entry into T cells.

In a study by Feng (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.03.27.20045427v1.full.pdf+html), spleens and lymph nodes from six COVID-19 patients with post-mortem examinations were collected and inspected for viral presence in resident macrophages, B cells and T cells. Immunochemistry demonstrated that SARS-CoV-2 nucleoprotein could be detected in ACE2+, CD169+ macrophages in spleen and lymph nodes, while no viral infection could be found in T cells and B cells. Moreover, it was observed that SARS-CoV-2 infection induces severe tissue damage including lymph follicle depletion, splenic nodule atrophy, histiocyte hyperplasia and lymphocyte reductions. The authors suggest that lymphocytopenia that is prevalent in COVID-19 patients might be caused by viral infected macrophages inducing lymphocyte apoptosis, mediated by Fas/FasL signalling.

Other observations

Angeletti (J Med Vir 2020, see ***below***) used sequence analysis and modelling to predict features of SARS-Cov-2 pathogenicity. He suggested that the stabilizing mutation falling in the endosome-associated-protein-like domain of the nsp2 protein could account for COVID-19 high transmission capability, while the destabilizing mutation in nsp3 proteins could suggest a potential mechanism differentiating COVID-19 from SARS.

Fahmi (Infect Genet Evol. 2020, see ***below***) showed that two non-structural proteins, NS7b and NS8, were exclusively conserved among SARS-CoV-2, βCoV_RaTG, and BatSARS-like Cov. NS7b and NS8 have previously been shown to affect immune response signalling in the SARS-CoV experimental model. Thus, the authors speculated that the properties of these accessory proteins, NS7b and NS8, in SARS-CoV-2 may affect its ability to infect humans.

Pathological observations from biopsies and autopsies

A manuscript by Tian (J Thorac Oncol 2020, see ***below***) describes examinations of biopsies of 2 asymptomatic cancer patients who underwent surgery and were later found to have been infected with SARS-CoV-2. The lungs of both patients exhibited oedema, proteinaceous exudate with globules, focal hyperplasia of pneumocytes with only patchy inflammatory cellular infiltration, and multinucleated giant cells. Hyaline membranes were not prominent. These observations likely represent an early phase of the lung pathology of COVID-19 pneumonia.

Xu (Lancet Resp Med 2020, see ***below***) described for the first time pathology findings from biopsies collected at autopsy. The pathological features of COVID-19 greatly resemble those seen in SARS and MERS. In addition, the liver biopsy specimens of the patient with COVID-19 showed moderate microvascular steatosis and mild lobular and portal activity, indicating the injury could have been caused by either SARS-CoV-2 infection or drug-induced liver injury. There were a few interstitial mononuclear inflammatory infiltrates, but no other substantial damage in the heart tissue.

Zhang (Ann Int Med 2020, see ***below***) presented the histopathologic changes seen on post-mortem transthoracic needle biopsies from a patient with COVID-19 who had respiratory failure and radiographic bilateral ground-glass opacities. Nonspecific findings consistent with diffuse alveolar damage were observed. Immunostaining of lung sections with an antibody to the Rp3 N protein of SARS-CoV-2 revealed prominent expression on alveolar epithelial cells, including damaged, desquamated cells within the alveolar space. In contrast, viral protein expression was minimally detectable on blood vessels or in the interstitial areas between alveoli.

Barnes (J Exp Med 2020, see ***below***) studied the function of neutrophils and their ability to form neutrophil extracellular traps (NETs), which may contribute to organ damage and mortality in COVID-19. The authors showed lung infiltration of neutrophils in an autopsy specimen from a patient who succumbed to COVID-19. Prior reports extensively linked aberrant NET formation to pulmonary diseases, particularly ARDS. Intravascular NETs have been

shown to play a vital role in initiating and accreting thrombosis in arteries and veins. NETs may also be involved in the cytokine storm.

Mechanisms of enhanced disease

Antibody-dependent enhancement (ADE) occurs when antibodies facilitate viral entry into host cells and enhance viral infection in these cells. ADE has been observed for a variety of viruses, most notably flaviviruses (e.g., dengue virus). ADE has been observed for coronaviruses. Several studies have shown that sera induced by SARS-CoV spike enhance viral entry into Fc receptor-expressing cells (Wan, Shang, Sun et al J Vir 2020, see ***below***). One study demonstrated that unlike receptor-dependent viral entry, serum-dependent SARS-CoV entry does not go through the endosome pathway. Additionally, it has long been known that immunization of cats with feline coronavirus spike leads to worsened future infection due to the induction of infection-enhancing antibodies. Wan et al. further studied the molecular mechanism of ADE using MERS-CoV and a monoclonal antibody as a model.

A publication by Tetro (preprint available in Microb Inf 2020: https://reader.elsevier.com/reader/sd/pii/S1286457920300344?token=0E0B1A0532BEFAD83CBA48B5118C612C3C0AB30DB736B57A27E49972594314494E48D01DF5E0F17D3215A26D15466C2) further described the hypothesis that ADE due to prior exposure to other coronaviruses could underlie the severity of cases in the Hubei province. In the context of identifying the priming coronavirus, he noted that as the introduction of SARS-CoV into humans has been suggested to have occurred in the Hubei Province. However, SARS-CoV is not likely to be a predominant priming virus for ADE to SARS-CoV-2. Seroprevalence studies have shown a very low level of SARS-CoV seroconversion in the population apart from workers with direct contact with animals such as traders.

Alternatively, Fu (Virol Sin 2020, see ***below***) speculated that a mechanism of ADE of viral infection occurs in some patients with early, sub-optimal antibody activity that cannot completely clear the virus, but instead leads to persistent viral replication and inflammation.

Molloy (Pediatr Res 2020, see ***below***) suggested that a possible reason for the disparity in severity between adults and children may relate to differences in receptors in the renin-angiotensin system and altered inflammatory responses to pathogens.

Mechanisms of myocardial injury

Both Guo (JAMA Cardiol 2020, see ***below***) and Shi (JAMA Cardiol 2020, see ***below***) observed that myocardial injury is significantly associated with fatal outcome of COVID-19 in China. A review of the importance of myocarditis in COVID-19 was published by Madjid (JAMA Cardiol 2020, see below), who suggested that myocardial injury is likely associated with infection-related myocarditis and/or ischemia, and provides an important prognostic factor in COVID-19. Bonow (JAMA Cardiol 2020, see ***below***) further discussed the observation that patients with pre-existing cardiovascular disease are susceptible to the most adverse complications of COVID-19, and the fact that the mechanisms responsible for these outcomes remain largely unknown. Bonow also pointed to a mechanism of demand ischemia that devolves into myocardial injury or plaque disruption stimulated by intense systemic inflammatory stimuli. SARS-CoV-2 can elicit an intense release of multiple cytokines and chemokines that may lead not only to vascular inflammation and plaque instability but also to myocardial inflammation. Direct viral infection of the myocardium is another possible causal pathway of myocardial damage. The affinity of SARS-CoV-2 for the host ACE2 receptor also raises the possibility of direct viral infection of vascular endothelium and myocardium. It is thus possible that in some patients with or without pre-existing cardiovascular disease, COVID-19-associated myocardial injury could represent myocarditis.

Chen (Cardiovasc Res 2020, see ***below***) found that pericytes with high expression of ACE2 might act as the target cardiac cell of SARS-CoV-2. The pericytes injury due to virus infection may result in capillary endothelial cells dysfunction, inducing microvascular dysfunction. Patients with basic heart failure disease showed increased ACE2 expression at both mRNA and protein levels, meaning that if infected by the virus these patients may have higher risk

of heart attack and critically ill condition. This study may explain the high rate of severe cases among COVID-19 patients with basic cardiovascular disease

Signs of liver injury

Guan (Zhonghua Gan Zang Bing Za Zhi 2020, see ***below***) investigated the possible mechanism of liver injury in patients. ALT and AST are indeed abnormally elevated in some patients, especially in severe disease cases. The author assumed that in addition to the over-activated inflammatory response in patients with COVID-19 pneumonia, the up-regulation of ACE2 expression in liver tissue caused by compensatory proliferation of hepatocytes derived from bile duct epithelial cells may also be the possible mechanism of liver tissue injury.

A publication by Xu (Liver Int 2020, see ***below***) provided a summary of available information on SARS-CoV-2 and liver injury. The authors noted that the liver injury observed in COVID-19 patients might be caused by lopinavir/ritonavir, and that there is still a lack of reports that liver failure occurs in COVID-19 patients with chronic liver diseases.

Neurotropism?

Li, Bai et Hashikawa (J Med Vir 2020, see ***below***), considering the similarities of the disease with SARS-CoV and MERS-CoV, proposed a potential neuroinvasion of SARS-CoV-2 to be partially responsible for the acute respiratory failure of COVID-19 patients. A similar hypothesis has been raised by Steardo (Acta Physiol 2020, see ***below***).

Conde Cardona (J Neurol Sci 2020, see ***below***) presented a series of arguments supporting the contention that that respiratory distress is not only the result of pulmonary inflammatory structural damage, but also due to the damage caused by the virus in the respiratory centers of the brain. These arguments included for instance the neurological symptoms observed in a subset of the patients (incl. anosmia and dysgeusia), detection of the virus genome in the cerebrospinal fluid of a patient, as well as presence of receptors of ACE2 in the cerebral vascular endothelium and its self-regulatory function, causing elevation of cerebral blood pressure.

Hyperinflammation and acute respiratory distress syndrome

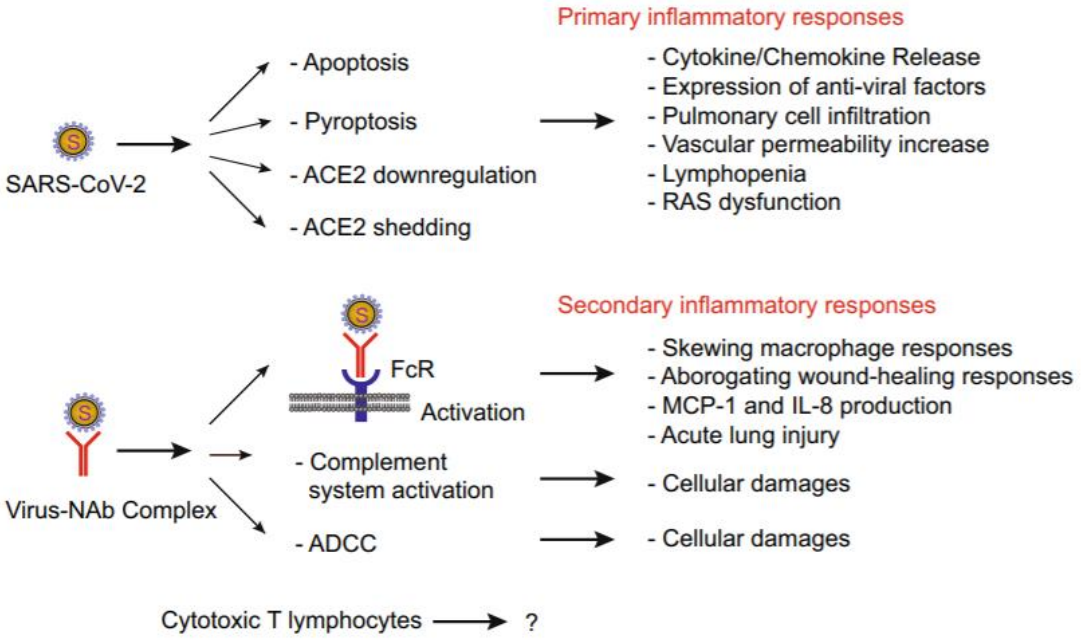
Similar to patients with SARS-CoV and MERS-CoV, some patients with COVID-19 develop acute respiratory distress syndrome (ARDS) with characteristic pulmonary ground glass changes on imaging (Zumla Lancet 2020). COVID-19 is also associated with increases in IL-6, IL-10, IL-2 and IFN-γ levels in the peripheral blood in the severe cases compared to those in the mild cases (Liu on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.16.20023671v1). Accumulating evidence indicates that part of the severe COVID-19 patients have an elevated cytokine profile resembling the cytokine storm described in SARS and MERS (Zhang Clin Imm, see ***below***). The observations have been found consistent with the characteristics of the so called “primary cytokine” storm induced by viral infection which were mainly produced by alveolar macrophages, epithelial cells and endothelial cells, rather than those observed in “secondary cytokine” storm induced by different subsets of activated T lymphocytes in late stage of viral infection or a complication of T cell-engaging therapies.

In line with these observations, Liao (see Observations in COVID-19 patients ***above***) showed that monocyte-derived FCN1+ macrophages, but not FABP4+ alveolar macrophages that represent a predominant macrophage subset in BALF from patients with mild diseases, overwhelm in the severely damaged lungs from patients with ARDS. These cells are highly inflammatory and enormous chemokine producers implicated in cytokine storm.

Fu (Virol Sin 2020, see ***below***) explored the possible mechanisms of the inflammatory response observed in COVID-19 pneumonia. Based on previous studies of SARS-CoV, he separated the inflammatory responses in SARS-CoV-2 infection into primary and secondary responses (Figure 8). Primary inflammatory responses occur early after viral infection, prior to the appearance of neutralizing antibodies (NAb). These responses are mainly driven by active viral replication, viral-mediated ACE2 downregulation and shedding, and host antiviral responses. Secondary inflammatory responses

begin with the generation of adaptive immunity and NAb. The virus-NAb complex can also trigger FcR-mediated inflammatory responses and acute lung injury.

Figure 8 Possible mechanisms of SARS-CoV-2-mediated inflammatory responses (from Fu Virol Sin 2020).



Interestingly, Ong (Cell Host & Microbe 2020: https://marlin-prod.literatumonline.com/pb-assets/journals/research/cell-host-microbe/chom_2283_s5.pdf) found a highly dynamic expression of pro-inflammatory genes in COVID-19. Expression of most of these genes peaked after nadir of respiratory function, which questions a cytokine storm hypothesis. Instead the authors' data hints at the possibility that the IL1 pathway may be a more suitable correlate of severe respiratory disease.

The cytokine profile associated with COVID-19 disease severity has been reported as characterised by increased IL-2, IL-7, granulocyte-colony stimulating factor, interferon-γ inducible protein 10, monocyte chemoattractant protein 1, macrophage inflammatory protein 1-α, and tumour necrosis factor-α. Predictors of fatality have been found to include elevated ferritin and IL-6, suggesting that mortality might be due to virally driven hyperinflammation (Mehta Lancet 2020, see ***below***).

Ji (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.24.20025437v1) described the use of TWIRLS, an automated topic-wise inference method based on massive literature, to suggest a possible mechanism of SARS-CoV-2 pathogenicity. The method yielded the hypothesis that after triggering functional changes in ACE2/AT2R, an imbalance in the steady-state cytokine regulatory axis involving the Renin-Angiotensin System and IP-10 leads to a cytokine storm.

Ciceri (Crit Care Resusc 2020, see ***below***) suggested "MicroCLOTS" (microvascular COVID-19 lung vessels obstructive thromboinflammatory syndrome) as a new name for severe pulmonary COVID-19. The authors hypothesised that, in predisposed individuals, alveolar viral damage is followed by an inflammatory reaction and by microvascular pulmonary thrombosis. This progressive endothelial thromboinflammatory syndrome may also involve the microvascular bed of the brain and other vital organs, leading to multiple organ failure and death.

Magro (Transl Res 2020, see ***below***) examined skin and lung tissues from 5 patients with severe COVID-19 characterized by respiratory failure (n=5) and purpuric skin rash (n=3) by light microscopy and immunohistochemistry. No viral cytopathic changes were observed and the diffuse alveolar damage with hyaline membranes, inflammation, and type II pneumocyte hyperplasia, hallmarks of classic ARDS, were not prominent. These pulmonary findings were

accompanied by significant deposits of terminal complement components C5b-9 (membrane attack complex), C4d, and MASP2, in the microvasculature, consistent with sustained, systemic activation of the alternative and lectin-based complement pathways. The purpuric skin lesions similarly showed a pauci-inflammatory thrombogenic vasculopathy, with deposition of C5b-9 and C4d in both grossly involved and normally-appearing skin. In addition, there was co-localization of COVID-19 spike glycoproteins with C4d and C5b-9 in the inter-alveolar septa and the cutaneous microvasculature of two cases examined. In conclusion, at least a subset of sustained, severe COVID-19 may define a type of catastrophic microvascular injury syndrome mediated by activation of complement pathways and an associated procoagulant state.

Co-infections

A study by Wang (manuscript non-peer reviewed on MedRxiv : https://www.medrxiv.org/content/10.1101/2020.02.12.20022327v1.full.pdf) analysed 613 patients with fever who underwent multiple tests for 13 respiratory pathogens. Interestingly, 5.8% of patients with SARS-CoV-2 infection were reported to be co-infected with coronavirus (3/104), influenza A virus (2/104), rhinovirus (2/104), and/or influenza A H3N2 (1/104).

Similarly, respiratory virus, fungi and bacteria co-infections were reported by Ai (on MedRxiv https://www.medrxiv.org/content/10.1101/2020.02.13.20022673v1).

A case report on co-infection with SARS-CoV-2 and Influenza A Virus in a patient with pneumonia in China has also been presented (Wu Emerg Inf Dis 2020, see ***below***).

Lin (Sci China Life Sci 2020, see ***below***) reported on the use of a multiplex RT-PCR method (multiplex rapid detection kit 2.0, Uni-MEDICA Tech, Shenzhen), which can simultaneously detect 15 respiratory tract infection pathogens including the SARS-CoV-2, was employed to screen the pathogen agents in the patients. These 15 respiratory pathogens are SARS-CoV-2, influenza A/B, coronavirus NL63, coronavirus, parainfluenza virus type 1/2/3(PIV1/2/3), adenovirus, rhinovirus (hRV), human bocavirus, coronavirus HKU1 (HKU1), coronavirus OC43, human metapneumovirus (hMPV) and respiratory syncytial virus (RSV). A total of 186 suspected COVID-19 cases were tested. In the 92 SARS-CoV-2 (49.46%) positive patients, the common respiratory viruses RSV, hRV, hMPV, PIV2 and HKU1 were also simultaneously detected in six patients (3.2%) respectively, of which four patients (2.2%) were positive for at least two detected viruses. The co-infections in these six patients were further verified in parallel testing using a second-day sampling from the same patients.

Zhu (J Med Vir 2020, see ***below***) reported on a severe case involving co-infection of SARS-CoV-2 and **HIV**. Unfortunately, the publication does not provide details as to the time of HIV diagnosis.

Animal models

On the basis of sequence analyses, Wan, Shang, Graham et al. (J Vir 2020, see ***below***) predicted that either SARS-CoV-2 or laboratory mice and rats would need to be genetically engineered before a robust mouse or rat model for COVID-19 would become available. By contrast, the authors noted that pigs, ferrets, cats, and non-human primates contain largely favourable SARS-CoV-2 -contacting residues in their ACE2 and hence may serve as animal models for SARS-CoV-2.

Transgenic mice

A manuscript by Bao (on BioRxiv : https://www.biorxiv.org/content/10.1101/2020.02.07.939389v2) presented data supporting the suitability of the SARS-CoV transgenic mouse model for SARS-CoV2. The hACE2 transgenic mice were inoculated intranasally at a dosage of 10^5 TCID50 per mouse. Weight loss of up to 5% was observed for 10 dpi only in the infected mice. Other clinical symptoms were not observed. The typical histopathology was interstitial

pneumonia with significant inflammatory cells infiltration around the bronchioles and blood vessels, and viral antigens were observed in bronchial epithelial cells and alveolar epithelial cells. The phenomenon was not found in wild type mice infected with SARS-CoV-2.

Golden Syrian Hamsters

Chan (Clin Infect Dis 2020, see ***below***) established a readily available small animal model for COVID-19 using golden Syrian hamster (*Mesocricetus auratus*). The Syrian hamster could be consistently infected by SARS-CoV-2. Maximal clinical signs of rapid breathing, weight loss, histopathological changes from the initial exudative phase of diffuse alveolar damage with extensive apoptosis to the later proliferative phase of tissue repair, airway and intestinal involvement with virus nucleocapsid protein expression, high lung viral load, and spleen and lymphoid atrophy associated with marked cytokine activation were observed within the first week of virus challenge. The lung virus titre was between 10^5-10^7 TCID50/g. Challenged index hamsters consistently infected naïve contact hamsters housed within the same cage, resulting in similar pathology but not weight loss. All infected hamsters recovered and developed mean serum neutralising antibody titre ≥1:427 fourteen days post-challenge. Immunoprophylaxis with early convalescent serum achieved significant decrease in lung viral load but not in lung pathology.

Ferrets

A communication by CSIRO, the Commonwealth Scientific and Industrial Research Organisation in Australia, on March 9, suggested that ferrets are susceptible to SARS CoV-2, the team claiming that the virus replicates in the animal host (https://www.csiro.au/en/Research/Health/Infectious-dieases-coronavirus/Latest-updates).

Kim (Cell Host Micr 2020, see ***below***) subsequently reported a ferret model of SARS-CoV-2 infection and transmission that recapitulates aspects of human disease. SARS-CoV-2-infected ferrets exhibited elevated body temperatures and virus replication. Although fatalities were not observed, SARS-CoV-2-infected ferrets shed virus in nasal washes, saliva, urine and faeces up to 8 days post infection. At 2 days post-contact, SARS-CoV-2 was detected in all naïve direct contact ferrets. Furthermore, a few naïve indirect contact ferrets were positive for viral RNA, suggesting airborne transmission. Viral antigens were detected in nasal turbinate, trachea, lungs, and intestine with acute bronchiolitis present in infected lungs.

Cynomolgus macaques

Rockx (Science 2020, see ***below***) showed that SARS-CoV-2 infection in cynomolgus macaques results in COVID-19-like disease with prolonged virus excretion from nose and throat in absence of clinical signs.

Rhesus macaques

Callaway (Nature 2020, see ***below***) provided a summary of the current status of research on COVID-19 animal models. He pointed to the preprint by Chao Shan at the Chinese Academy of Sciences Wuhan Institute of Virology, who found that rhesus macaques infected with SARS-CoV-2 had a fairly mild illness. None developed fevers, but X-rays of their lungs showed signs of pneumonia similar to those in humans with COVID-19. This was confirmed after some of the monkeys were euthanized and their lungs dissected. The researchers killed two monkeys three days after infection and another pair after six days. They monitored two further animals for three weeks; these monkeys lost some weight, but didn't seem to have other serious symptoms.

Deng (non-peer-reviewed manuscript on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.03.13.990036v1.full.pdf) presented data suggesting that macaques can be infected with SARS-CoV-2 via the conjunctival route. Viral load and distribution in the macaques infected by this route were comparatively high in the nasolacrimal system, while relatively mild and local in the lung compared with those in macaques inoculated via intratracheal routes. This publication refers to the contrasting observation that no SARS-CoV-2 could be detected by RT-PCR in 114 conjunctival swabs samples 28 from patients with COVID-19 pneumonia.

Bao (non-peer-reviewed manuscript on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.03.13.990226v1.full.pdf) studied the possibility of **reinfection** in a rhesus macaque model of infection. Following the initial intratracheal infection, none of the animals developed fever, but three of the four monkeys showed weight loss ranging from 200 g to 400 g. Other clinical signs such as reduced appetite, increased respiration rate and hunched posture were transient after the initial challenge. Viral loads in nasal and pharyngeal swabs peaked at 3 days post-infection (dpi) and then declined naturally. Similarly, viral loads from anal swabs reached the peak at 3 dpi and then declined to undetectable level at 14 dpi. Chest X-ray at 7 dpi showed that the upper lobe of the right lung had varying degrees of the localized infiltration and interstitial markings, showing the mild to bilateral ground-glass opacification. Two infected monkeys (M3 and M4) were intratracheally re-challenged at 28 dpi. None of the monkeys showed the weight loss after re-exposure, but a transient elevation of body temperature was observed in both re-exposed monkeys. Viral loads in nasopharyngeal and anal swabs tested negative after SARS-CoV-2 re-exposure. The neutralizing antibody titer of one of the 2 monkeys increased after re-challenge (Table 9).

Table 9 SARS-CoV-2 neutralizing antibody titers in infected monkeys (from Bao on BiorXiv)

Animal ID	Primary challenge		Rechallenge	
	21 dpi	28 dpi	5 dpr	14 dpr
M1[a]	NE	NE	NE	NE
M2[b]	1:16	1:16	NE	NE
M3[c]	1:8	1:8	1:8	NE
M4	1:16	1:16	1:40	1:40

Notes: a M1 was euthanized and necropsied at 7 dpi. NE, not examined.

b M2 was continuously monitored without rechallenge. NE, not examined.

c M3 was euthanized and necropsied at 5 dpr. NE, not examined.

Yu (Animal Model Exp Med. 2020, see ***below***) found that SARS-CoV-2 caused more severe interstitial pneumonia in old monkeys than that in young monkeys. Monkeys developed typical interstitial pneumonia characterized by thickened alveolar septum accompanied with inflammation and oedema; notably, old monkeys exhibited diffuse severe interstitial pneumonia. Viral antigens were detected mainly in alveolar epithelial cells and macrophages.

Epidemiology

Disease emergence

On 31 December 2019, the Wuhan Municipal Health Commission announced a cluster of cases of viral pneumonia of unexplained aetiology (Wu Eurosurv 2020, see ***below***). The Southern China Seafood Wholesale Market in Wuhan was suspected to be related to 27 pneumonia cases without identified pathogenic agents that were reported in late December 2019. Most of the early cases were reportedly either shop owners, largely in the West District of the Southern China Seafood Wholesale Market, or people who visited the market before symptom onset. This market is a large open complex including sections selling seafood, fresh meat, produce, other perishable goods, and a very wide variety of live wild animals for consumption. Environmental disinfection of the Southern China Seafood Wholesale Market was initiated on 30 December 2019 and the market was closed on 1 January 2020.

Host range & search for intermediate animal hosts

In both the SARS-CoV and MERS-CoV epidemics, the viruses have likely originated from bats and then jumped into another amplification mammalian host [the Himalayan palm civet (*Paguma larvata*) for SARS-CoV and the dromedary

camel (*Camelus dromedarius*) for MERS-CoV] before crossing species barriers to infect humans (Chan Em Micr Inf 2020, see ***below***). While phylogenetic analysis indicates a bat origin of SARS-CoV-2, the virus also potentially recognizes the ACE2 receptor from a diversity of animal species (except mice and rats), implicating these animal species as possible intermediate hosts or animal models for SARS-CoV-2 infections (Wan J Virol 2020, see ***below***). As explained by Andersen (Nature Med 2020, see ***below***), detailed understanding of how an animal virus jumped species boundaries to infect humans so productively will help in the prevention of future zoonotic events. If SARS-CoV-2 pre-adapted in another animal species, then there is the risk of future re-emergence events. In contrast, if the adaptive process occurred in humans, then even if repeated zoonotic transfers occur, they are unlikely to take off without the same series of mutations.

Ji (J Med Virol. 2020, see ***below***) suggested that snake is the most probable wildlife animal reservoir for SARS-CoV-2 based on its relative synonymous codon usage bias resembling snake compared to other animals. However, this hypothesis was received with skepticism (https://www.nature.com/articles/d41586-020-00180-8). It was not supported by the bioinformatics protein structure and sequence analyses by Zhang (manuscript on Arxiv: https://arxiv.org/abs/2002.03173).

Chinese researchers of the South China Agricultural University in Guangzhou found 99% sequence similarity in the S RBD region between SARS-CoV-2 isolated from infected human subjects and coronaviruses taken from pangolins (*Manis javanica*) (https://www.nature.com/articles/d41586-020-00364-2). Researchers had noted previously that coronaviruses are a possible cause of death in pangolins, and that SARS-CoV-2 and coronaviruses from pangolins use receptors with similar molecular structures to infect cells. Lam (Nature 2020, see ***below***) also reported the identification of SARS-CoV-2-related coronaviruses in pangolins seized in anti-smuggling operations in southern China. Metagenomic sequencing identified pangolin-associated CoVs that belong to two sub-lineages of SARS-CoV-2-related coronaviruses, including one very closely related to SARS-CoV-2 in the receptor-binding domain. Cyranoski (Nature 2020, see ***below***) subsequently summarized the investigations pertaining to the animal source of SARS-CoV-2. He noted that the previously communicated 99% homology between SARS-CoV-2 and a pangolin virus only applied to the S RBD region. The homology with pangolin viruses when considering the whole genome did not exceed 92.4%. A subsequent report by Zhang (Current Biology 2020, see ***below***) reached similar conclusions. By contrast, SARS-CoV shared 99.8% of its genome with a civet coronavirus.

A systematic comparison and analysis to predict the interaction between the RBD of the S protein and the ACE2 receptor suggested that not only pangolins, but also turtles (*C. picta bellii*, *C. mydas*, and *P. sinensis*) may act as potential intermediate hosts transmitting SARS-CoV-2 to human (Liu Xiao et al. J Med Vir 2020, see ***below***).

ACE2 contains at least five key amino acids critical for binding S protein of SARS-CoV-2. Based on these five amino acids, Luan (Biochem Biophys Res Commun 2020, see ***below***) analyzed the corresponding amino acids of different mammals to determine which mammalian ACE2 could interact with the SARS-CoV-2 S protein. The authors found that the ACE2 of *Camelus dromedarius*, *Procyon lotor*, *Rhinolophus ferrumequinum*, *Rattus norvegicus*, *Mus musculus*, *Ornithorhynchus anatinus*, *Loxodonta africana*, *Erinaceus europaeus*, *Nyctereutes procyonoides*, *Suricata suricatta*, *Dipodomys ordii*, and *Cavia porcellus* are not able to associate with S protein. The authors indicated cat/dog ACE2 may bind to S protein of SARS-CoV-2. The ACE2 proteins from Circetidae, incl. *Mesocricetus auratus* (golden hamster) and *Cricetulus griseus* (Chinese hamster). Similarly, a study by Luan (J Med Vir 2020, see ***below***) also suggested that ACE2 proteins from Cricetidae were able to associate with SARS-CoV-2 RBD. The authors found a similar result for Bovidae.

Field studies and laboratory challenge data remain important to conduct for better understanding the zoonotic transmission of SARS-CoV-2. One of these studies was conducted by Deng (Transbound Em Dis 2020, see ***below***), who after confirming the specificity, sensitivity and suitability of SARS-CoV-2 ELISA kit for different species of experimental animals, evaluated clinical serum samples from domestic livestock (pig, cow, sheep, horse), poultry (chicken, duck, goose), experimental animal (mice, rat, and rhesus monkey), companion animal (dog and cat),

and wild animals (camel, fox, mink, alpaca, ferret, bamboo rat, peacock, eagle, tiger rhinoceros, pangolin, leopard cat, jackal, giant panda, masked civet, porcupine, bear, yellow-throated marten, weasel, red pandas, and wild boar). All serum samples had negative results, which made the authors conclude that the animal species above can be excluded as intermediate host of SARS-CoV-2. Of note, no SARS CoV-2 specific antibodies were detected in all dogs and cats, even for the street dogs and cats in Wuhan City and the pet dog raised by a COVID-19 patient.

Of note, while controversies about the source of the virus and its intermediate host remain, Li (Infect Genet Evol 2020, see ***below***) evaluated coronaviruses derived from five wild animals, including *Paguma larvata*, *Paradoxurus hermaphroditus*, Civet, *Aselliscus stoliczkanus* and *Rhinolophus sinicus* (Chinese rufous horseshoe bat). Genome and ORF1a homology showed that SARS-CoV-2 is not the same coronavirus as the coronavirus derived from these five animals, whereas the authors confirmed the highest homology with Bat coronavirus isolate RaTG13.

Human to human transmission

Han (Infl Other Resp Inf 2020, see ***below***) published a very good summary of available information on the different transmission modes of SARS-CoV-2.

Of note, a repository developed by Xu (Lancet Inf Dis 2020) provides open-access information on COVID-19 cases detected in Wuhan and the rest of the world: https://docs.google.com/spreadsheets/d/1itaohdPiAeniCXNlntNztZ_oRvjh0HsGuJXUJWET008/edit#gid=0

Early observations

In the 99 patients cohort reported by Chen (Lancet 2020, see ***below***), 49 (49%) patients had a history of exposure to the Huanan seafood market, where wild animals were served at a restaurant. Among them, there were 47 patients with long-term exposure history, most of whom were salesmen or market managers, and two patients with short-term exposure history, who were shoppers. None of the patients were medical staff. These early data suggested that a point-source zoonotic (animal-to-human) route was likely the main mode of transmission of the disease (Nishiura J Clin Med2020, see ***below***). However, the reporting of a family cluster including a family member, who did not travel to Wuhan, but became infected with the virus after several days of contact with four of the family members, soon provided strong evidence of human-to-human transmission (Chan Lancet 2020, see ***below***). In this cluster none of the family members had contacts with Wuhan markets or animals, although two had visited a Wuhan hospital. In line with this observation, the genetic epidemiology data suggest that from the beginning of December, 2019, when the first cases were retrospectively traced in Wuhan, the spread of infection has been almost entirely driven by human-to-human transmission, not the result of continued spillover (see https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30374-3/fulltext and ***above***)

Transmission mode

The mechanisms of transmission of SARS-CoV-2 remain largely unknown. As for other respiratory viruses, contact, droplet and airborne routes of transmission are suspected (Shiu 2019, see ***below***). However, indirect transmission of the virus may also occur. Cai (Em Inf Dis 2020, see ***below***), for instance, investigated a cluster of COVID-19 cases associated with a shopping mall in Wenzhou, China. Data suggested transmission perhaps resulting from virus contamination of common objects, virus aerosolization in a confined space, or spread from asymptomatic infected persons.

Respiratory secretions and saliva

Virus shedding has been demonstrated in multiple studies that analysed respiratory secretions by RT-PCR testing (see for instance Zou NEJM 2020 ***below***; more detailed data on virus shedding are presented in section ***Virus load*** above).

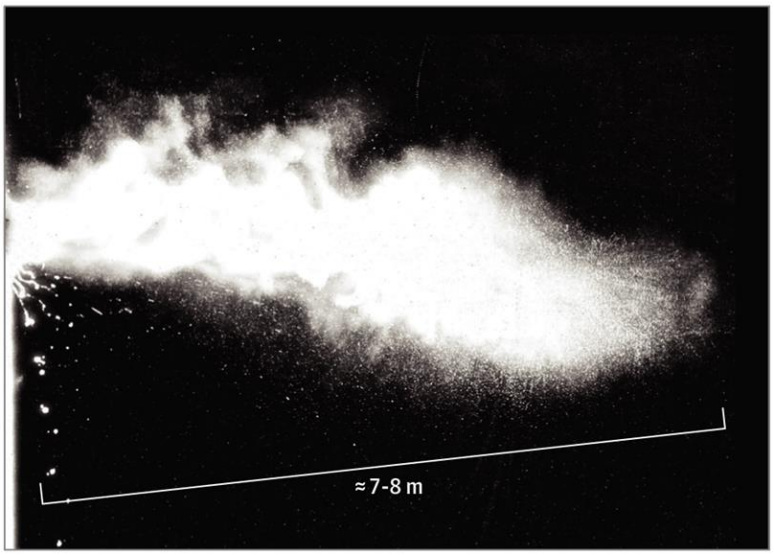
The duration of shedding (as measured by RT-PCR) has been found highly variable. A study by Zhou (Clin Inf Dis, see ***below***) reported virus detection in throat samples for a median duration of 31.0 (IQR: 24.0-40.0) days from illness onset, ranging between 18 and 48 days.

How SARS-CoV-2 viral load as detected by RT-PCR correlates with culturable virus still needs to be better studied. A study by To (Clin Inf Dis 2020, see ***below***), which tested saliva samples from a few RT-PCR confirmed COVID-19 patients, found positive viral cultures for 3 patients and negative for 2 patients. Wölfel (Nature 2020, see ***below***) isolated infectious virus from throat- and lung-derived samples, but not from stool samples despite high virus RNA load. Virus shedding data remain critical to inform public health interventions, especially when considering that patients with few or no symptoms can have detectable viral RNA in the oropharynx for at least 5 days (see ***Transmission by asymptomatic or pre-symptomatic subjects*** and ***Transmission by recovered patients*** below).

Respiratory droplet emissions are typically dichotomized into "large" and "small" droplets. Large droplets settle faster than they evaporate, contaminating the immediate vicinity of the infected individual. In contrast, small droplets evaporate faster than they settle (Bourouiba JAMA 2020, see ***below***). In this model, as small droplets transition from the warm and moist conditions of the respiratory system to the colder and drier outside environment, they evaporate and form residual particulates made of the dried material from the original droplets. These residual particulates are referred to as aerosols. Such classification systems employ various arbitrary droplet diameter cutoffs, from 5 to 10 µm, to categorize host-to-host transmission as droplets or aerosol routes.

However, recent work has demonstrated that exhalations, sneezes, and coughs not only consist of mucosalivary droplets following short-range semiballistic emission trajectories but are primarily made of a multiphase turbulent gas cloud that entrains ambient air and traps and carries within it clusters of droplets with a continuum of droplet sizes. The locally moist and warm atmosphere within the turbulent gas cloud allows the contained droplets to evade evaporation for much longer than occurs with isolated droplets. Under these conditions, the lifetime of a droplet could be considerably extended by a factor of up to 1000, from a fraction of a second to minutes. Given various combinations of an individual patient's physiology and environmental conditions, such as humidity and temperature, the gas cloud and its payload of pathogen-bearing droplets of all sizes can travel 23 to 27 feet (7-8 m) (Figure 9). Although no studies have directly evaluated the biophysics of droplets and gas cloud formation for patients infected with the SARS-CoV-2 virus, several properties of the exhaled gas cloud and respiratory transmission may apply to this pathogen. The authors noted that recommendations to maintain a 1 or 2-meter distance away from a person showing symptoms of disease, such as coughing and sneezing, may not be sufficient, and that currently used surgical and N95 masks are not tested for these potential characteristics of respiratory emissions.

Figure 9 Multiphase Turbulent Gas Cloud From a Human Sneeze (from Bourouiba JAMA 2020)



Conjunctiva

Two samples of tear and conjunctival secretions obtained from a COVID-19 patient with conjunctivitis yielded positive RT-PCR results (Xia J Med Vir 2020, see ***below***). A manuscript by Sun (on MedRxiv:

https://www.medrxiv.org/content/10.1101/2020.02.26.20027938v1) reported a similar observation, with SARS-COV-2 RNA detected in ocular discharges in one patient with conjunctivitis. Although conjunctivis is a rare symptom of COVID-19 (observed in 2.8% of patients in this study), the authors suggested a potential route of nosocomial infection through the eyes after occupational exposure. However, a subsequent publication by Peng (J Med Vir 2020, see) rather indicated that the detection of SARS-CoV-2 RNA in tears and conjunctival secretions of very few COVID-19 patients complicated with conjunctivitis is a coincident event, rather than a causal event of SARS-CoV-2 infection of the conjunctiva. Similarly, Seah (Ophtalmology 2020, see ***below***) evaluated virus shedding in tears in 17 COVID-19 patients. All tear samples showed negative results, even when nasopharyngeal swab samples continued to show positive results. Furthermore, patients with symptoms of upper respiratory tract infections did not demonstrate any viral shedding in tears, suggesting that the hypothesis of the lacrimal duct as a viral conduit may not be true. Most importantly, only 1 patient showed ocular symptoms during the disease course, and no evidence of SARS-CoV-2 could be found in the tear samples. This suggests that transmission through tears regardless of the phase of infection likely is low.

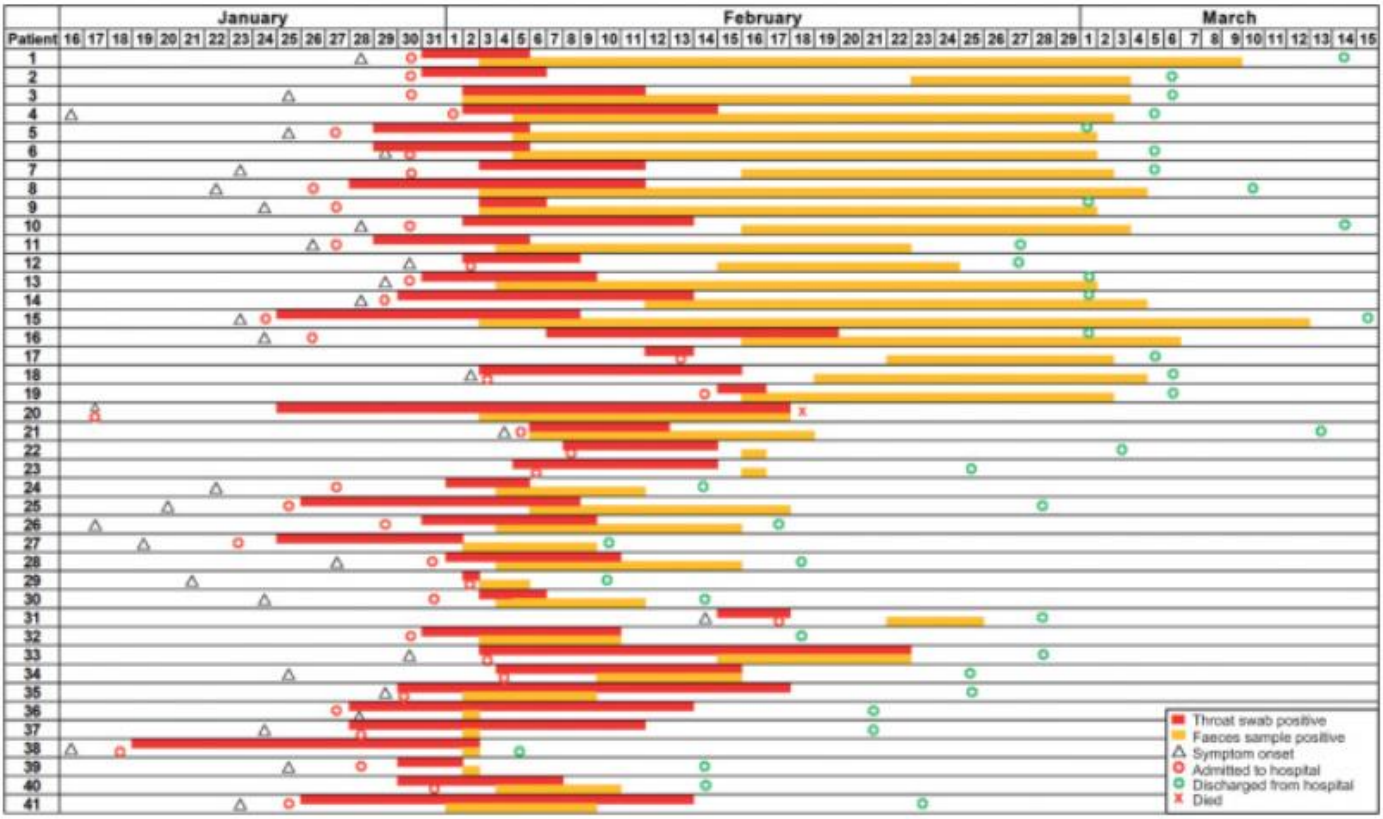
However, Colavita (Ann Intern Med. 2020, see ***below***) demonstrated that ocular fluids from SARS-CoV-2-infected patients may contain **infectious virus**. The first RNA-positive ocular sample of a 65-year-old woman, who had travelled from Wuhan to Italy, was inoculated in Vero E6 cells, and cytopathic effect was observed 5 days postinoculum. Viral replication was confirmed by real-time RT-PCR on RNA purified from spent cell growth medium.

Faecal excretion

Zhang (in Emerg Micr Inf 2020, see ***below***) also reported presence of the virus in anal swabs and blood, with more anal swab positives than oral swab positives in a later stage of infection. Xiao (https://www.medrxiv.org/content/10.1101/2020.02.17.20023721v1) found 53.42% of patients testing positive in stool. 23.29% of the patients remained positive in faeces even after the viral RNA decreased to undetectable level in respiratory tract. The observation that 14 out of 138 patients (10 percent) in a Wuhan hospital (Wang JAMA 2020, see ***below***) initially presented with diarrhoea and nausea one or two days prior to development of fever and dyspnoea also supported the hypothesis of faecal transmission of the virus. A similar observation had already been made with the first U.S. patient diagnosed with COVID-19, who also experienced loose bowel movements for two days and subsequent viral RNA detection in stool.

Wu (Lancet Gastroenterol Hepatol 2020, see ***below***) presented real-time RT-PCR results of respiratory and faecal samples from COVID-19 patients. Faecal samples from 33 (45%) of 74 patients were negative for SARS CoV-2 RNA, while their respiratory swabs remained positive for a mean of 15·4 days (SD 6.7) from first symptom onset. Of the 41 (55%) of 74 patients with faecal samples that were positive for SARS-CoV-2 RNA, respiratory samples remained positive for SARS-CoV-2 RNA for a mean of 16·7 days (SD 6.7) and faecal samples remained positive for a mean of 27·9 days (10.7) after first symptom onset. The full disease course of the 41 patients with faecal samples that were positive for SARS-CoV-2 RNA is shown in Figure 10. Notably, patient 1 had positive faecal samples for 33 days continuously after the respiratory samples became negative, and patient 4 tested positive for SARS-CoV-2 RNA in their faecal sample up to 47 days after first symptom onset.

Figure 10 Timeline of results from throat swabs and faecal samples through the course of disease for patients with SARS-CoV-2 RNA positive faecal samples (from Wu Lancet Gastroenterol Hepatol. 2020)



Similarly, from a cohort of 42 patients, Chen, Chen et al. (J Med Vir 2020, see ***below***) identified 18 (64.29%) patients who remained positive for viral RNA in faeces after pharyngeal swabs turned negative. Viral shedding in faeces continued for 7 (6-10) days after pharyngeal swabs became negative, regardless of COVID-19 severity.

In a meta-analysis of 60 studies, comprising 4243 COVID-19 patients, the pooled prevalence of all gastrointestinal symptoms was 17.6% (95% CI, 12.3%-24.5%); 11.8% of patients with non-severe COVID-19 had gastrointestinal symptoms (95% CI, 4.1%-29.1%) and 17.1% of patients with severe COVID-19 had gastrointestinal symptoms (95% CI, 6.9%-36.7%) (Cheung Gastroenterol 2020, see ***below***). The pooled prevalence of stool samples that were positive for virus RNA was 48.1% (95% CI, 38.3%-57.9%); of these samples, 70.3% of those collected after loss of virus from respiratory specimens tested positive for the virus (95% CI, 49.6%-85.1%).

Vertical transmission

Preliminary studies suggested the absence of vertical transmission of SARS-CoV-2 (see for instance Chen Lancet 2020, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30360-3/fulltext). Subsequent reports seemed to largely support this contention, but the possibility that vertical transmission might occur in some cases cannot be completely ruled out (see Pregnancy and newborns ***above***).

Blood products

SARS-CoV-2 shedding in plasma or serum is common, which leads to a theoretical risk of transmission of coronaviruses through transfusion of blood products. Chang (Transfus Med Rev 2020, see ***below***) noted that because more and more asymptomatic infections are being found among COVID-19 cases, considerations of blood safety and coronaviruses have arisen especially in endemic areas.

Semen

A study by Song (Biol Reprod 2020, see ***below***) analysed semen samples collected from 12 patients in their recovery phase, as well as in testicular samples from one patient who died of COVID-19 during the acute phase. All samples were negative by RT-PCR, suggesting that SASR-CoV-2 does not infect the testis and the male reproductive tract.

Social drivers of transmission

While the basic reproductive number only captures the average dynamics of transmission, a crucial question for control is whether specific situations and settings might be driving the epidemic (Liu Lancet 2020, see ***below***). The secondary attack rate (SAR), defined as the probability that an infection occurs among susceptible people within a specific group (i.e., household or close contacts), can provide an indication of how social interactions relate to transmission risk.

Drawing on data from nine recent reports of secondary transmission associated with a specific event such as a meal or holiday visit, Liu estimated that 48 secondary infections occurred among 137 attendees. Assuming that all these secondary infections were generated by a single primary case, which is probable given the short-term nature of the exposure events, would imply a SAR among close contacts of 35% (95% CI 27–44). More data are needed to reliably estimate the true within-household and between-household transmission for SARS-CoV-2; recent reports might be biased towards larger transmission events. However, if it transpires that most at-risk contacts have a close relationship with cases, and superspreading events tend to occur at large gatherings of these close contacts measures to reduce infection risk during such gatherings and subsequent tracing of close contacts of cases might have a disproportionate effect on reducing overall transmission.

Travel

A retrospective analysis of early data found a significant association between domestic travel by train and the number of COVID-19 cases in China, whereas the associations of the other two means of transportation (car, flight) failed to reach statistical significance (Zhao Travel Med Inf Dis 2020, see ***below***). However, a subsequent analysis by Chen (Chin Med J 2020, see ***below***), based on cases up to Jan 30 and population migration data extracted from Baidu Qianxi, found a correlation coefficient between the provincial number of cases and emigration from Wuhan up to 0.943.

Zheng (Trav Med Inf Dis 2020, see ***below***) studied the spatial transmission of COVID-19 via public and private transportation in China, and found a significant and positive association between the frequency of flights, trains, and buses from Wuhan and the daily as well as the cumulative numbers of COVID-19 cases in other cities with progressively increased correlations for trains and buses.

A study by Lau (J Microbiol Immunol Infect 2020, see ***below***) indicated that the number of flight routes as well as total passenger volume are highly relevant risk factors for the spread of current COVID-19.

Qifang Bi on MedRxiv (https://www.medrxiv.org/content/10.1101/2020.03.03.20028423v1) studied 391 cases and 1286 close contacts identified by the Shenzhen CDC. In this dataset, cases were found older than the general population (mean age 45) and balanced between males (187) and females (204). Household contacts and those travelling with a case where at higher risk of infection (ORs 6 and 7) than other close contacts. The household secondary attack rate was 15%.

Mass gatherings

Ebrahim (Trav Med Inf Dis 2020, see ***below***) highlighted the fact that mass gatherings, both those clearly defined and those spontaneously occurring, are key determinants of epidemiologic expansion of disease outbreaks. The authors noted that COVID-19 has already provided examples of both clearly planned event cancellations such as the Umrah suspension in Saudi Arabia, and situations where outbreaks and events were continued.

Superspreading events

Frieden (Em Inf Dis 2020, see ***below***) noted that there have been multiple reports of superspreading events, which are associated with both explosive growth early in an outbreak and sustained transmission in later stages. The authors highlighted a major limitation of the concept of R_0, the basic reproductive number, which is presented as a mean or median value and does not capture the heterogeneity of transmission among infected persons.

Debora MacKenzie (New Scientist 2020, see ***below***) referred to modelling data suggesting that only 10 per cent of cases are responsible for 80 per cent of transmission. If this effect is real, the likelihood that the epidemic will die out increases, especially if super-spreading events can be limited.

Transmission by asymptomatic or pre-symptomatic subjects

Numerous reports provide data supporting the contention that asymptomatic (or pre-symptomatic) subjects can transmit COVID-19 with high efficiency (Chang Lancet Resp Med 2020, see ***below***). The possibility of transmission by asymptomatic individuals is a critical question, as it directly impacts public health responses to the epidemic.

The following evidence was obtained both from epidemiological observations and laboratory testing of asymptomatic subjects during the first weeks of the epidemic:

- A boy aged 10 years who was infected with COVID-19 had no symptoms but had visible changes in lung imaging and blood markers of disease.
- Another patient undergoing surgery in a hospital in Wuhan infected 14 health-care workers (HCWs) even before fever onset.
- A patient who travelled from Shanghai to attend a meeting in Germany was subclinical until on the flight back to China. However, two of this patient's close contacts and another two patients attending the meeting without close contact were found to be infected with COVID-19.
- Yu (J Inf Dis 2020, see ***below***) reported on a familial cluster of four patients in Shanghai, of which one was an 88 year-old man with moving difficulties who was only exposed to his asymptomatic family members who developed symptoms later
- Hoehl (NEJM 2020, see ***below***) reported that in the effort to evacuate 126 people from Wuhan to Frankfurt, a symptom-based screening process was ineffective in detecting SARS-CoV-2 infection in 2 persons who later were found to have evidence of SARS-CoV-2 in a throat swab.
- Zhou (NEJM 2020, see ***below***) analysed the viral load in one asymptomatic patient and found it similar to that in symptomatic patients, which suggests the transmission potential of asymptomatic or minimally symptomatic patients.
- Bai (JAMA 2020, see ***below***) described a case of transmission from a presumed asymptomatic carrier with one positive PCR, but normal chest CT findings.
- Luo (Chin Med J 2020, see ***below***) identified a confirmed case of asymptomatic SARS-CoV-2 infection in a 50-year old woman. Despite largely normal laboratory and chest CT findings, her persistent positivity of the virus nucleic acid in her throat swabs and anal swabs for at least 17 days suggested that she was very likely a healthy carrier.
- Tang (Emerg Infect Dis 2020, see ***below***) reported on an asymptomatic child who was positive for SARS-CoV-2 by RT PCR in a stool specimen 17 days after the last virus exposure. The child was virus positive in stool specimens for at least an additional 9 days.
- Kam (Clin Inf Dis 2020, see ***below***) described a 6-month-old infant with COVID-19, who had persistently positive nasopharyngeal swabs to day 16 of admission, but no clinical signs or symptoms apart from a single transient temperature of 38.5°C.
- Pan (Lancet Inf Dis, see ***below***) described two individuals who were under active surveillance because of a history of exposure to infected patients and showed positive results on RT-PCR a day before disease onset.

- Tong (Emerg Infect Dis. 2020, see ***below***) described 2 infections resulting from contact with a potentially pre-symptomatic traveller from the city of Wuhan.
- Huang (J Inf 2020, see ***below***) monitored a cluster of close-contacts of a 22-year-old male with laboratory-confirmed COVID-19 in Anhui Province.

Subsequent studies aimed at quantifying the role of transmission by asymptomatic subjects.

Du (non-peer reviewed manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.19.20025452v1) analyzed 468 infector-infectee pairs with confirmed COVID-19 cases reported in China between January 21, 2020, and February 8, 2020. Interestingly, 12.1% of reports indicated pre-symptomatic transmission.

Hu (Sci China Life Sci 2020, see ***below***) presented the clinical characteristics of 24 cases with asymptomatic infection screened from close contacts and the transmission potential of asymptomatic COVID-19 virus carriers in Nanjing, China. None of the 24 asymptomatic cases presented any obvious symptoms when nucleic acid screening was performed. Five cases (20.8%) developed symptoms (fever, cough, fatigue, etc.) during hospitalization. Twelve (50.0%) cases showed typical CT images of ground-glass chest and 5 (20.8%) presented stripe shadowing in the lungs. The remaining 7 (29.2%) cases showed normal CT image and had no symptoms during hospitalization. These 7 cases were younger (median age: 14.0 years; P=0.012) than the rest. None of the 24 cases developed severe COVID-19 pneumonia or died. The median communicable period, defined as the interval from the first day of positive nucleic acid tests to the first day of continuous negative tests, was 9.5 days (up to 21 days). A typical asymptomatic transmission to the cohabiting family members, which caused severe COVID-19 pneumonia.

As indicated by Nishiura (Int J Inf Dis 2020, see ***below***), the asymptomatic ratio is conventionally estimated using sero-epidemiological data. However, collection of such data requires significant logistical effort, time, and cost. Instead, the authors estimated the asymptomatic ratio by using information on Japanese nationals that were evacuated from Wuhan, China on chartered flights. Based on this very small sample size, the asymptomatic ratio was estimated at 30.8% (95% confidence interval (CI): 7.7%, 53.8%) among evacuees. Mizumoto (Euro Surveill 2020, see ***below***) derived the delay-adjusted asymptomatic proportion of infections cases on board the Diamond Princess cruise ship. The estimated asymptomatic proportion reached a somewhat lower value of 17.9% (95% credible interval (CrI): 15.5-20.2%), overlapping the confidence interval of the estimate of Nishiura.

Day (BMJ 2020, see ***below***) reported the story of an Italian village, where identifying and isolating asymptomatic people helped eliminate the virus. Interestingly, testing performed on approx. 3000 individuals showed that a majority of people infected with SARS-CoV-2 (50-75%) were asymptomatic. Similarly, Kimball (MMWR 2020, see ***below***) reported facility-wide testing in long-term care facility, which identified a 30.3% prevalence of infection among residents. Approximately half of the residents with positive test results did not have any symptoms at the time of testing.

Another interesting set of data was published by Zhou (Clin Microb Inf 2020, see ***below***), who monitored a cohort of 13 patients who were asymptomatic at the time of diagnosis. 12/13 presented with radiographic abnormalities from the time of diagnosis; 4/13 presented signs of radiographic progression; only 3/13 developed symptoms of the disease from 2 days after diagnosis. All patients became negative by PCR by day 18 at the latest.

He (Nat Med 2020, see ***below***) reported temporal patterns of viral shedding in 94 patients with laboratory-confirmed COVID-19 and modelled COVID-19 infectiousness profiles from a separate sample of 77 infector-infectee transmission pairs. The highest viral load was observed in throat swabs at the time of symptom onset, and the authors inferred that infectiousness peaked on or before symptom onset. They estimated that 44% (95% confidence interval, 25-69%) of secondary cases were infected during the index cases' presymptomatic stage.

Transmission by recovered patients

Lan (JAMA 2020, see ***below***) reported data suggesting that at least a proportion of recovered patients still may be virus carriers. In this study four patients with COVID-19 who met criteria for hospital discharge or discontinuation of quarantine in China (absence of clinical symptoms and radiological abnormalities and 2 negative RT-PCR test results) had positive RT-PCR test results 5 to 13 days later, while they were continuing the quarantine protocol at home for 5 days. All patients had 3 repeat RT-PCR tests performed over the next 4 to 5 days and all were positive. An additional RT-PCR test was performed using a kit from a different manufacturer and the results were also positive for all patients. The patients continued to be asymptomatic by clinician examination and chest CT findings showed no change from previous images. They did not report contact with any person with respiratory symptoms. No family member was infected.

Ling (Chin Med J 2020, see ***below***) analysed, in 66 convalescent patients, the clearance time and factors influencing viral RNA detection in different samples from patients with COVID-19. A majority of patients had a longer duration until stool specimens were negative for viral RNA than for throat swabs, with a median delay of 2.0 (1.0-4.0) days. Only 6.9% urine samples were positive for viral nucleic acid; viral RNA was still present in three patients' urine specimens after throat swabs were negative. Using a multiple linear regression model ($F = 2.669$, $P = 0.044$, and adjusted $R2 = 0.122$), the analysis showed that the CD4+ T lymphocyte count may help predict the duration of viral RNA detection in patients' stools ($t = -2.699$, $P = 0.010$). The duration of viral RNA detection from oropharyngeal swabs and faecal samples in the glucocorticoid treatment group was longer than that in the non-glucocorticoid treatment group (15 days vs. 8.0 days, respectively; $t = 2.550$, $P = 0.013$) and the duration of viral RNA detection in faecal samples in the glucocorticoid treatment group was longer than that in the non-glucocorticoid treatment group (20 days vs. 11 days, respectively; $t = 4.631$, $P < 0.001$).

Chen (Int J Inf Dis 2020, see ***below***) also reported a confirmed case of COVID-19 whose oropharyngeal swab test of SARS-CoV-2 RNA turned positive during convalescence.

Xing (Eurosurv 2020, see ***below***) also reported detection of RNA in two asymptomatic cases out of 62 recovered patients (3.23%). Mao (Int J Inf Dis 2020, see ***below***) similarly reported two cases of positive RT-PCR in asymptomatic (recovered) patients. Among the recurrence cases described by Jiang (J Inf 2020, see ***below***), one case had significant post-discharge clinical symptoms and discomfort for nine days, one case had a mild cough, and 4 cases were asymptomatic with positive RT-PCR nucleic acid test.

Yuan (Clin Inf Dis 2020, see ***below***) provided additional evidence of virus shedding from recovered patients. The study population included 172 discharged COVID-19 patients from Jan 23th 2020 to Feb 21th 2020, of which 25 patients (total 14.5%) subsequently developed a positive RT-PCR result. These 25 patients (median age of 28 years) had an average of 7.32±3.86 days from their last negative RT-PCR result to turning positive again.

A study by Tang (Infect Control Hosp Epidemiol. 2020, see ***below***) showed that among all 209 discharged coronavirus 2019 patients in Shenzhen between January 23 and February 21, 2020, 9 (4.3%) patients showed RT-PCR positive in throat swabs, 13 (6.2%) patients showed RT-PCR positive in anal swabs, and 22 (10.5%) positive in either type. The time between discharge and positive RT-PCR tests was 4.7 days on average.

Of note, A case report by Qu (Trav Med Inf Dis 2020, see ***below***) pointed to the importance of the specimen choice. Both a throat swab and sputum were collected before the patient was discharged. SARS-COV-2 nucleic acid was still detectable in sputum while the throat swab was negative.

Estimates of key epidemiological parameters

Serial interval

The serial interval of COVID-19 is defined as the time duration between a primary case (infector) developing symptoms and secondary case (infectee) developing symptoms (Du Em Inf Dis 2020, see ***below***). Obtaining robust estimates for the distribution of COVID-19 serial intervals is a critical input for determining the reproduction number which can indicate the extent of interventions required to control an epidemic. The serial intervals reported by Du had a mean of 3.96 days (95% confidence interval: 3.53-4.39), a standard deviation of 4.75 days (95% confidence interval: 4.46-5.07), and 12.6% of reports indicating pre-symptomatic transmission.

Subsequently, from the analysis of a total of 28 infector-infectee pairs, Nishiura (Int J Inf Dis 2020, see ***below***) estimated the median serial interval at 4.0 days (95% credible interval [CrI]: 3.1, 4.9). Limiting our data to only the most certain pairs, the median serial interval was estimated at 4.6 days (95% CrI: 3.5, 5.9). Considering that the serial interval of COVID-19 is close to or shorter than its median incubation period, the data suggest that a substantial proportion of secondary transmission may occur prior to illness onset.

Zhao (Infect Control Hosp Epidemiol. 2020, see ***below***) evaluated 48 transmission events including 21 in Hong Kong and 27 in Shenzhen. The authors found find that the serial interval had been decreasing by 0.4 (95%CI: 0.1−0.7) per day, or 6.2% (95%CI: 0.4−11.6%) in percentage, from January 10 to February 2 in Hong Kong and Shenzhen. The Pearson correlation coefficient between the serial interval and calendar date was estimated at −0.37 with p-value < 0.01. The serial interval of male primary cases was 3.5 days (95%CI: 1.2−5.7) shorter than that of a female primary case, or 49.7% (95%CI: 15.3−70.1%) less in percentage.

The systematic review of COVID-19 epidemiology by Park (J Clin Med 2020, see ***below***), which included 41 studies, estimated the serial interval to be 4-8 days.

Reproductive number

Different estimates of the basic reproductive number (R_0) were reported from a number of studies since the start of the epidemic (see Table 10).

A preliminary R_0 estimate of 1.4-2.5 was presented at the "meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV)" (https://www.who.int/news-room/detail/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))

Liu (J Trav Med 2020, see ***below***) had previously presented an overview of published R_0 estimates for the disease, and found the average R_0 to be 3.28 and median 2.79.

Zhao (J Trav Med 2020, see ***below***) subsequently demonstrated that using an overestimated serial interval leads to overestimation of R_0, and found an R_0 at 2.0 when using a more recent estimate of the serial interval at 4.6 days.

Table 10 Published estimates of R_0 (adapted from Liu J Trav Med 2020)

Study	Location	Study date	Methods	Approaches	R_0 estimates (average)	95% CI
WHO	China	18 January 2020	/	/	1.4–2.5 (1.95)	/
Joseph	Wuhan	31 December 2019–28 January 2020	Stochastic Markov Chain Monte Carlo methods (MCMC)	MCMC methods with Gibbs sampling and non-informative flat prior, using posterior distribution	2.68	2.47–2.86

Study	Location	Study date	Methods	Approaches	R_0 estimates (average)	95% CI
Shen	Hubei province	12–22 January 2020	Mathematical model, dynamic compartmental model with population divided into five compartments: susceptible individuals, asymptomatic individuals during the incubation period, infectious individuals with symptoms, isolated individuals with treatment and recovered individuals	R0 = β/αβ = mean person-to-person transmission rate/day in the absence of control interventions, using nonlinear least squares method to get its point estimateα = isolation rate = 6	6.49	6.31–6.66
Liu	China and overseas	23 January 2020	Statistical exponential Growth, using SARS generation time = 8.4 days, SD = 3.8 days	Applies Poisson regression to fit the exponential growth rateR0 = 1/M(−r)M = moment generating function of the generation time distributionr = fitted exponential growth rate	2.90	2.32–3.63
Liu	China and overseas	23 January 2020	Statistical maximum likelihood estimation, using SARS generation time = 8.4 days, SD = 3.8 days	Maximize log-likelihood to estimate R0 by using surveillance data during a disease epidemic, and assuming the secondary case is Poisson distribution with expected value R0	2.92	2.28–3.67
Read	China	1–22 January 2020	Mathematical transmission model assuming latent period = 4 days and near to the incubation period	Assumes daily time increments with Poisson-distribution and apply a deterministic SEIR metapopulation transmission model, transmission rate = 1.94, infectious period =1.61 days	3.11	2.39–4.13
Majumder	Wuhan	8 December 2019 and 26 January 2020	Mathematical Incidence Decay and Exponential Adjustment (IDEA) model	Adopted mean serial interval lengths from SARS and MERS ranging from 6 to 10 days to fit the IDEA model,	2.0–3.1 (2.55)	/
Cao	China	23 January 2020	Mathematical model including compartments Susceptible-Exposed-Infectious-Recovered-Death-Cumulative (SEIRDC)	R = K 2 (L × D) + K(L + D) + 1L = average latent period = 7,D = average latent infectious period = 9,K = logarithmic growth rate of the case counts	4.08	/
Zhao	China	10–24 January 2020	Statistical exponential growth model method adopting serial interval from SARS (mean = 8.4 days, SD = 3.8 days) and MERS (mean = 7.6 days, SD = 3.4 days)	Corresponding to 8-fold increase in the reporting rateR0 = 1/M(−r)r =intrinsic growth rateM = moment generating function	2.24	1.96–2.55
Zhao	China	10–24 January 2020	Statistical exponential growth model method adopting serial interval from SARS (mean = 8.4 days, SD = 3.8 days) and MERS (mean = 7.6 days, SD = 3.4 days)	Corresponding to 2-fold increase in the reporting rateR0 = 1/M(−r)r =intrinsic growth rateM = moment generating function	3.58	2.89–4.39
Imai (2020)	Wuhan	January 18, 2020	Mathematical model, computational modelling of potential epidemic trajectories	Assume SARS-like levels of case-to-case variability in the numbers of secondary cases and a SARS-like generation time with 8.4 days, and set number of cases caused by zoonotic exposure and assumed total number of cases to estimate R0 values for best-case, median and worst-case	1.5–3.5 (2.5)	/
Julien and Althaus	China and overseas	18 January 2020	Stochastic simulations of early outbreak trajectories	Stochastic simulations of early outbreak trajectories were performed that are	2.2	

Study	Location	Study date	Methods	Approaches	R_0 estimates (average)	95% CI
				consistent with the epidemiological findings to date		
Tang	China	22 January 2020	Mathematical SEIR-type epidemiological model incorporates appropriate compartments corresponding to interventions	Method-based method and Likelihood-based method	6.47	5.71–7.23
Qun Li	China	22 January 2020	Statistical exponential growth model	Mean incubation period = 5.2 days, mean serial interval = 7.5 days	2.2	1.4–3.9
Lai[5]					2.6 (range 2.1-5.1)	
Sanche[6]					4.7 - 6.6	2.8 - 11.3
Yang[7]					3.77	3.51-4.05
Li[8]					2.2	1.4-3.9
Zhao[9]					2.24	1.96-2.55
Zhao[10]					3.58	2.89-4.39
Riou[11]					median 2.2	90% high density interval: 1.4–3.8
Zhou[12]					2.8 - 3.3 or 3.2 - 3.9	
Wu[13]					2·68	2·47-2·86
Liu[14]					3.28	
Shao[15]					3.25≤ R_0 ≤3.4	
Sanche[16]					median 5.7	3.8–8.9

Of note, some authors (e.g. Cao, manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.01.27.20018952v1.full.pdf; or Lai J Med Vir 2020, see below) have referred to the effective reproduction number (R, the expected number of secondary cases generated by an infectious case once an epidemic is underway), which has been presented as a more accurate definition than the basic reproduction number.

Liu (on MedRxiv: https://www.biorxiv.org/content/10.1101/2020.01.25.919787v1.full) reported that the temporal distribution of R values showed declining trend from 7.93 (95%CI: 5.00-12.00) to 2.60 (95%CI: 0.57-5.17). Such temporal effect was also observed by Kucharski (Lancet Inf Dis 2020, see ***below***), who estimated that the median daily reproduction number (Rt) in Wuhan declined from 2.35 (95% CI 1.15–4.77) 1 week before travel restrictions were introduced on Jan 23, 2020, to 1.05 (0.41–2.39) 1 week after. Interestingly, Kucharski's model also found that in

[5] J Med Vir 2020
[6] https://www.medrxiv.org/content/10.1101/2020.02.07.20021154v1
[7] https://www.medrxiv.org/content/10.1101/2020.02.10.20021675v1
[8] NEJM 2020
[9] Int J Infect Dis 2020
[10] Int J Infect Dis 2020
[11] Eurosurv 2020
[12] https://onlinelibrary.wiley.com/doi/epdf/10.1111/jebm.12376
[13] Lancet 2020
[14] https://academic.oup.com/jtm/advance-article/doi/10.1093/jtm/taaa021/5735319
[15] https://www.medrxiv.org/content/10.1101/2020.02.17.20023747v2
[16] Emerg Infect Dis 2020

locations with similar transmission potential to Wuhan in early January, once there are at least four independently introduced cases, there is a more than 50% chance the infection will establish within that population.

The systematic review of COVID-19 epidemiology by Park (J Clin Med 2020, see ***below***), which included 21 estimates for the basic reproduction number ranging from 1.9 to 6.5, noted that 13/21 estimates were found between 2.0 and 3.0.

Attack rate of the disease

Information is still lacking as to the incidence of the disease in various populations. However, some publications have assessed the disease prevalence in specific cohorts of subjects.

A study by Wang (Trav Med Inf Dis 2020, see ***below***) estimated the prevalence of COVID-19 in 2004 participants under home quarantine in Shenzhen. Of people who provided clear travel history, 129 people have travelled to Wuhan city and 1,046 people have travelled to other cities in Hubei province within 14 days before the home quarantine. Few (less than 1%) participants reported contact history with confirmed or suspected cases during their trip and most arrived in Shenzhen more than a week before the study. Three cases were found in the cohort, corresponding to 1.5‰ prevalence (95% CI: 0.31‰-4.37‰).

Contact tracing of 2,370 individuals from the first 30 COVID-19 cases in Korea indicated that the risk of symptomatic cases from transmission to contacts was low at 0.55% (95% CI 0.31–0.96) (COVID-19 National Emergency Response Center Osong Public Health Res Perspect 2020, see ***below***). However, the findings also suggested that the transmission of COVID-19 was significant among household contacts: there were 119 household contacts, of which 9 individuals developed COVID-19 resulting in a secondary attack rate of 7.56% (95% CI 3.7–14.26), which is in line with other reports. In the earlier reports, familial clusters of COVID-19 had been reported and household transmission was thought to be a major driver in the spread of the outbreak in the community. Of the first 262 COVID-19 cases in Beijing, China, 133 (50.8%) were family cluster cases. In the US, active symptom monitoring was performed for 445 close contacts of the 12 cases with travel-related COVID-19, resulting in symptomatic cases with a secondary attack rate of 0.45% (95% CI, 0.12–1.6) among all contacts, and 10.5% (95% CI, 2.9–31.4) among household members.

Li (Clin Inf Dis 2020, see ***below***) enrolled 105 index patients and 392 household contacts to determine the features of household transmission of COVID-19. Secondary transmission of SARS-CoV-2 developed in 64 of 392 household contacts (16.3%). The secondary attack rate to children was 4% comparing with 17.1% to adults. The secondary attack rate to the contacts within the households with index patients quarantined by themselves since onset of symptoms was 0% comparing with 16.9% to the contacts without index patients quarantined. The secondary attack rate to contacts who were spouses of index cases was 27.8% comparing with 17.3% to other adult members in the households.

Lytras (J Travel Med 2020, see ***below***) reported screening data from passengers on repatriation flights to Greece from the UK, Spain and Turkey. Despite almost all passengers being asymptomatic, many tested positive (3.6% from UK, 6.3% from Spain and 6.3% from Turkey).

Human to animal transmission and risk of back spillover

As SARS-CoV-2 infections are now widely distributed in the human population, there is a possibility for some animals to become infected through close contact with infected humans. Infection of animals with SARS-CoV-2 may have implications for animal health and welfare, and for wildlife conservation. On April 1st, the US Fish and Wildlife Service sent out a directive advising scientists to suspend all bat studies, concerned that researchers could spread the disease to bats. As such, back spillover events - the risk of SARS-COV-2 being introduced into endemic wildlife from humans - raises an additional concern and another serious public health threat. While containing the human outbreak is a priority, estimating the transmission potential and introduction of SARS-COV-2 in domestic and wild animals similarly requires immediate action, especially when considering viral discharge in the environment and survival times.

Domestic cats and dogs

Several dogs and cats have tested positive to SARS-CoV-2 following close contact with infected humans. However, viral load, route of infection, national and international context and age of pets may influence transmission probability (Shi , manuscript on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.03.30.015347v1).

- Two dogs from one household in Hong Kong were placed under quarantine on 18 March 2020 after their owner was hospitalized due to COVID-19 infection. Samples from one of the dogs tested positive for SARS-CoV-2. Both animals did not exhibit any specific clinical signs (Almendros Vet Rec 2020, see ***below***).
- Mallapaty (Nature 2020, see ***below***) discussed data from a manuscript on a preprint server showing that cats can be infected by SARS-CoV-2 in experimental conditions, and develop antibodies against the virus in the absence of disease symptoms. Virus transmission was observed in 1/3 cats exposed to infected animals. Dogs were not found to excrete infectious virus, and investigations in pigs, chickens and ducks identified no viral RNA in inoculated animals. Overall, none of these species is thought to play a part in the epidemiology of COVID-19.
- A Belgian cat belonging to a confirmed COVID-19 patient was also found positive. SARS-CoV-2 nucleic acid was detected in the stools and vomits of a cat showing clinical signs of digestive and respiratory disease. The presence of SARS-CoV-2 in the cat was confirmed by high throughput sequencing; productive infection was not established, but not ruled out.
- By contrast, Temmam (manuscript on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.04.07.029090v1) found no evidence of SARS-CoV-2 infection in 9 cats and 12 dogs in close contact with a cluster of 2 confirmed and 11 suspected COVID-19 patients in a veterinary campus in France.
- Noteworthy is the SARS-CoV-2 infection of a cat with respiratory illness, sneezing and ocular discharge belonging to a healthy household of Nassau County, New York. That cat was allowed to go outdoors in a COVID-19 affected neighbourhood.

It is advised that people treat pets as they would other human family members and to not let them interact with people or animals outside the household. It also recommended that if someone in the family develops symptoms, they also be isolated from pets.

Zoo animals

The Bronx zoo, Bronx County, New York, USA was the first to report infection in tigers and lions. A tiger at a zoo in New York, with mild respiratory clinical signs (dry, non-productive cough), was tested for several pathogens and found positive for SARS-CoV-2. This tiger was in contact with 7 other big cats, six of which also developed a mild respiratory illness (3 tigers and 3 lions), and one tiger that did not exhibit clinical signs; none were in respiratory distress. It is assumed that a pre-symptomatic or asymptomatic zoo keeper infected the first tiger (https://www.oie.int/wahis_2/public/wahid.php/Reviewreport/Review?page_refer=MapFullEventReport&reportid=33885).

Sanctuaries

On 13th March 2020, the International Primate Society together with the UICN Primates SG strongly recommended that great ape visitations by humans are reduced to the minimum needed to ensure the safety and health monitoring for the NHP. For those essential staff, great ape visitation rules need to be strictly enforced at all sites. While there has been no report of SARS-CoV-2 infection in wildlife sanctuaries so far, it is safest to assume that great apes are susceptible to SARS-CoV-2 infection (Melin, manuscript on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.04.09.034967v2). Patrono (Em Micr Inf 2020, see ***below***) reported a mild respiratory outbreak of βCoV 1 (HCov-OC43) in habituated Tai forest chimpanzees in Cote d'Ivoire. Viral RNA was

found in faeces of chimpanzees. The virus was probably introduced by asymptomatic visitors whose throat swabs tested positive for the virus.

Ranch mink

On 26th April, the Ministry of Agriculture of The Netherlands confirmed that two mink farms have reported cases of COVID-19 among their animals (https://www.reuters.com/article/us-health-coronavirus-netherlands-mink/mink-found-to-have-coronavirus-on-two-dutch-farms-ministry-idUSKCN2280FZ). Minks showed various symptoms including respiratory problems. An investigation has been launched to determine the source of the infections. Authorities assume that employees with COVID-19 symptoms infected the minks. The government immediately established a 400m buffer zone around the farms, closed the nearest public roads and banned transport of animals and manure from the infected farms.

At risk populations

Early publications provided preliminary analyses of the main risk factors of COVID-19. For instance, a retrospective, single-centre study, including all confirmed cases of COVID-19 in Wuhan Jinyintan Hospital from Jan 1 to Jan 20, 2020 described 99 patients with PCR-confirmed COVID-19 pneumonia (Chen Lancet 2020, see ***below***). Forty-nine (49%) had a history of exposure to the Huanan seafood market. The average age of the patients was 55.5 years (SD 13.1), including 67 men and 32 women. Fifty (51%) patients had chronic diseases. In this study, the disease was found more likely to affect older males with comorbidities. Subsequently, Yan (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.10.20021675v1) reported that out of a total of 8866 patients including 4021 (45.35%) laboratory confirmed patients , nearly half were aged 50 years or older (47.7%). There was a gender difference in incidence with 0.31 (male) vs. 0.27 (female) per 100 000 people (P<0.001).

Guan (Eur Respir J 2020, see ***below***) analysed the data from 1590 laboratory-confirmed hospitalised patients 575 hospitals in 31 province/autonomous regions/provincial municipalities across mainland China between December 11th, 2019 and January 31st, 2020. The mean age of patients was 48.9 years. 686 patients (42.7%) were females. Severe cases accounted for 16.0% of the study population. 131 (8.2%) patients reached to the composite endpoints. 399 (25.1%) reported having at least one comorbidity. The most prevalent comorbidity was hypertension (16.9%), followed by diabetes (8.2%). 130 (8.2%) patients reported having two or more comorbidities. After adjusting for age and smoking status, COPD [hazards ratio (HR) 2.681, 95% confidence interval (95%CI) 1.424-5.048], diabetes (HR 1.59, 95%CI 1.03-2.45), hypertension (HR 1.58, 95%CI 1.07-2.32) and malignancy (HR 3.50, 95%CI 1.60-7.64) were risk factors of reaching to the composite endpoints. The HR was 1.79 (95%CI 1.16-2.77) among patients with at least one comorbidity and 2.59 (95%CI 1.61-4.17) among patients with two or more comorbidities.

Similarly, a metaanalysis by Wang (Aging 2020, see ***below***) analysed six studies from China, including 324 severe cases and 1234 non-severe cases, which provided data in terms of hypertension, diabetes, and COPD. Hypertension, diabetes, COPD, cardiovascular disease, and cerebrovascular disease were found to be major risk factors for patients with COVID-19. The meta-analysis revealed no correlation between increased risk of COVID-19 and liver disease, malignancy, or renal disease.

Epidemiological data were also reported from other countries. For instance, a report of the Korean Society of Infectious Diseases; Korean Society of Pediatric Infectious Diseases; Korean Society of Epidemiology; Korean Society for Antimicrobial Therapy; Korean Society for Healthcare-associated Infection Control and Prevention; and Korea Centers for Disease Control and Prevention (J Korean Med Sci 2020, see ***below***) provided the key epidemiological features of the disease in Korea.

Jordan (BMJ 2020, see ***below***) provided a quick overview of previously reported observations that older age, cardiovascular disease, diabetes, chronic respiratory disease, hypertension, and cancer were all associated with an increased risk of death. A meta-analysis of eight studies including 46 248 patients with laboratory confirmed covid-19

indicated that those with the most severe disease were more likely to have hypertension (odds ratio 2.36 (95% confidence interval 1.46 to 3.83)), respiratory disease (2.46 (1.76 to 3.44)), and cardiovascular disease (3.42 (1.88 to 6.22)). In other studies, obesity and smoking were associated with increased risks. However, the authors noted that the relative importance of different underlying health conditions remains unclear, owing to inadequate adjustment for important confounding factors such as age, sex, and smoking status; insufficient follow-up; and likely under-reporting of pre-existing conditions. In China, health records are often incomplete or inaccurate and chronic conditions are underdiagnosed.

Risk factors

A retrospective study involving COVID-19 cases reported through February 11, 2020, and corresponding to 72 314 patient records including 44 672 (61.8%) confirmed cases, was reported by the Novel Coronavirus Pneumonia Emergency Response Epidemiology Team (Zhonghua Liu Xing Bing Xue Za Zhi 2020, see ***below***; and Wu Jama 2020, see ***below***). Among confirmed cases, most were aged 30-79 years (86.6%), diagnosed in Hubei (74.7%). The male-to-female ratio was 0.99:1 in Wuhan, 1.04:1 in Hubei, and 1.06:1 in China overall.

Yang (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.28.20028068v1), who analysed 55 cases in Beijing, also showed that compared with patients without pneumonia, those with pneumonia were 15 years older and had a higher rate of hypertension.

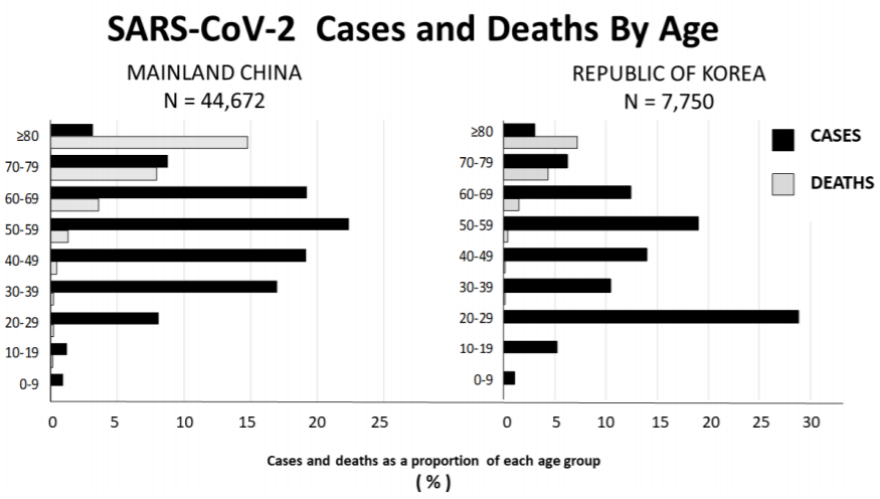
The characteristics of patients may also at least in part reflect the movement and the social activities of individuals in different societies (Korean Society of Infectious Diseases J Korean Med Sci 2020, see ***below***). In the Korean situation, for instance, a predominance of females and subjects in their 20s among COVID-19 cases may be due to the fact that the outbreak related to a religious group.

Age

Table 8 presented in ***Case fatality rate*** above, shows the risk of infection according to age as detected in the analysis of 72 314 patient records in China.

Dudley (Clin Inf Dis 2020, see ***below***), based on available data as of Feb 11 and March 11 respectively, compared the incidence of the disease and related deaths in China and South Korea (Figure 11). A bimodal distribution was observed in Korea, with highest morbidity in the 20-29 years cohort.

Figure 11 Incidence of disease and related death per age group in China and South Korea (from Dudley Clin Inf Dis 2020)



Interestingly, up to now, studies have only considered chronological age as a risk factor. As highlighted by Lauc (Aging 2020, see ***below***), a number of biomarkers aimed at objective estimation of biological age have been developed in the past several years, the most prominent ones being the epigenetic clock and the glycan clock. The repertoire of glycans

changes with age, especially in the age ranges that are most susceptible to SARS-CoV-2. Furthermore, both SARS-CoV-2 and its target ACE2 are known to be highly glycosylated, a pattern that likely changes with age. Recent study analysed site-specific N-linked glycosylation of MERS and SARS S glycoproteins, indicating that each of these glycosylation sites can be occupied by up to ten different glycans (called glycoforms), which greatly extends epitope diversity. The authors therefore recommended modern profiling technologies to be used to identify molecular risk factors of COVID-19.

Occupational risks

As noted by Koh (Occup Med 2020, see ***below***), a significant proportion of cases are related to occupational exposure. As this virus is believed to have originated from wildlife and then crossed the species barrier to infect humans, it is not unexpected that the first documented occupational groups at risk were persons working in seafood and wet animal wholesale markets in Wuhan. At the start of the outbreak, workers and visitors to the market comprised 55% of the 47 cases with onset before 1 January 2020, when the wholesale market was closed.

Health care workers (HCWs) were next recognized as another high-risk group to acquire this infection. In a case series of 138 patients treated in a Wuhan hospital, 40 patients (29% of cases) were HCWs. Among the affected HCWs, 31 (77.5%) worked on general wards, 7 (17.5%) in the emergency department, and 2 (5%) in the intensive care unit (ICU). In Singapore, among the first 25 locally transmitted cases, 17 cases (68%) were probably related to occupational exposure. They included staff in the tourism, retail and hospitality industry, transport and security workers, and construction workers. Sabino-Silva (Clin Oral Investig 2020, see ***below***) also highlighted the risks associated with the virus in saliva, especially for dentists and healthcare professionals that perform aerosol-generating procedures.

Genetics

As explained by Delanghe (Clin Chim Acta 2020, see ***below***), the ACE1 enzyme is characterized by a genetic deletion/insertion (D/I) polymorphism in intron 16, which is associated with alterations in circulating and tissue concentrations of ACE. The D allele is associated with a reduced expression of ACE2. This D/I polymorphism shows an important geographical variation. The log transformed prevalence of COVID-19 infections was found to inversely correlate with the D allele frequency: log (prevalence; number of cases/106 inhabitants) = 6.358–0.079 (D-allele frequency, %), r2 = 0.378; p = 0.001. The authors concluded that the ACE D/I genotype may affect the clinical course of the infection.

Smoking as a risk factor?

Cai (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.05.20020107v3) observed significantly higher ACE2 gene expression in former smoker's lung compared to non-smoker's lung. Also, the authors found higher ACE2 gene expression in Asian current smokers compared to non-smokers, but not in Caucasian current smokers, which may indicate an existence of gene-smoking interaction. In addition, they found that ACE2 gene is expressed in specific cell types related to smoking history and location. In bronchial epithelium, ACE2 is actively expressed in goblet cells of current smokers and club cells of non-smokers. In alveoli, ACE2 is actively expressed in remodelled AT2 cells of former smokers. Leung (Eur Respir J 2020, see ***below***) demonstrated increased ACE2 expression in the small airway epithelia of current (but not former) smokers and those with COPD. These results are consistent with previous observations in small animals wherein smoke exposure has been shown to upregulate both the expression and activity of ACE2 in the airways. While the up-regulation of ACE2 may be useful in protecting the host against acute lung injury, chronically, this may predispose individuals to increased risk of coronavirus infections.

Based on a review of published data as of 17 March 2020, Vardavas (Tobacco Induced Diseases 2020, see ***below***) concluded that smoking is most likely associated with the negative progression and adverse outcomes of COVID-19. Indeed, the authors identified five studies reporting data on the smoking status of patients infected with COVID-19. Notably, in the largest study that assessed severity (Guan NEJM 2020, see ***below***), there were higher percentages of current and former smokers among patients that needed ICU support, mechanical ventilation or who had died, and a higher percentage of smokers among the severe cases. From these published data Vardavas calculated that the

smokers were 1.4 times more likely (RR=1.4, 95% CI: 0.98–2.00) to have severe symptoms of COVID-19 and approximately 2.4 times more likely to be admitted to an ICU, need mechanical ventilation or die compared to non-smokers (RR=2.4, 95% CI: 1.43–4.04).

However, another review published in parallel by Lippi (Eur J Int Med 2020, see ***below***) reached different conclusions from the analysis of almost the same studies. The authors reported that in only one study (the study by Liu Chin Med J 2020, see ***below***), active smoking was found to be a significant predictor of COVID-19 severity, whilst in the other four studies the association was not statistically significant.

Cai (Lancet Resp Med 2020, see ***below***) also considered that the relatively small proportion of current smokers in reported studies compared with the proportion of male smokers in China (50·5%) are unlikely to be associated with incidence or severity of COVID-19.

Moreover, a study by Shi (Crit Care 2020, see ***below***) based on 487 patients, not included in any of these 2 reviews, did not identify smoking as a risk factor.

Obesity as a risk factor

An editorial by Ryan (Obesity 2020, see ***below***) noted that persons with obesity around the world are already at high risk for severe complications of COVID-19, by virtue of the increased risk of the chronic diseases that obesity drives. The authors also consider likely that obesity shall be an independent risk factor for COVID-19.

Up to now, only a few studies identified higher BMI as a risk factor for severe disease. Peng (Zhonghua Xin Xue Guan Bing Za Zhi 2020, see ***below***) for instance conducted a retrospective analysis on 112 COVID-19 patients with cardiovascular disease in Wuhan, from January 20, 2020 to February 15, 2020. Patients were divided into critical group (ICU, n=16) and general group (n=96) according to the severity of the disease. The BMI of the critical group was significantly higher than that of the general group (25.5 (23.0, 27.5) kg/m(2) vs. 22.0 (20.0, 24.0) kg/m(2), P=0.003). Patients were further divided into non-survivor group (n=17) and survivor group (n=95). Among the non-survivors, there were 88.24% (15/17) patients with BMI> 25 kg/m(2), which was significantly higher than that of survivors (18.95% (18/95), P<0.001).

The analysis of the clinical characteristics, treatment and prognosis of 280 patients from four Chinese hospitals (from January 20 to February 19, 2020) by Wu (J Intern Med 2020, see ***below***) also found that the severe group had a significantly higher BMI values than the group of patients with mild disease (25.8 ± 1.8 vs. 23.6 ± 3.2, P = 0.005). However, a multifactor analysis revealed that other factors (comorbidity, time from illness onset to antiviral treatment, and age >=65) were independent risk factors for COVID-19 progression. Additional studies on this important topic are thus still warranted.

Cancer as a risk factor

Liang (Lancet Oncol 2020, see ***below***) described a retrospective analysis of cancer patients among 1590 COVID-19 cases. Eighteen (1%; 95% CI 0·61–1·65) of 1590 COVID-19 cases had a history of cancer, which seems to be higher than the incidence of cancer in the overall Chinese population (285·83 [0·29%] per 100 000 people, according to 2015 cancer epidemiology statistics). Lung cancer was the most frequent type (5/18 patients).

Similarly, Sidaway (Nature Rev Clin Oncol 2020, see ***below***) provided a short overview of the evidence available to document the link between cancer and COVID-19. While data remain limited, patients with cancer seem to be both more likely to be diagnosed with COVID-19 and have more severe symptoms.

Other sources of risk

Folllowing a cross-sectional study conducted in 3947 participants in Vietnam, Nguyen (J Clin Med 2020, see ***below***) reported that people with S-COVID-19-S had a higher **depression** likelihood (OR, 2.88; p < 0.001) and lower Health Related Quality of Life-score (B, -7.92; p < 0.001).

Dyer (BMJ 2020, see ***below***) discussed the excess COVID-19 deaths among **African-Americans**, an observation related at least in part to a higher burden of underlying medical conditions such as diabetes, hypertension, obesity, and asthma among African-Americans. The author noted that the true scale of the disparity is unknown because few states and counties include racial data in their reporting. Another factor likely to be at play is the fact that many black people in the US work in essential jobs or in jobs that require in-person human interaction or cannot be done from home. Many also live in southern states, where Republican governors delayed lockdowns or played down the threat from the virus.

Risk factors of disease progression

Age and comorbidities

Multiple reports described the same risks factors leading to severe disease and death as those identified as disease risk factors. Wang (J Med Virol 2020, see below) reported the details of the first 17 deaths up to 24:00 pm 22 Jan 2020. The deaths included 13 males and 4 females. The median **age** of the deaths was 75 (range 48-89) years. The median days from first symptom to death were 14.0 (range 6-41) days, and tended to be shorter among people 70 years of age and above (11.5 [range 6-19] days) than those with ages below 70 years (20 [range 10-41] days, P=0.033).

Another study by Yang (Lancet 2020, see ***below***), which studied 52 critically ill adult patients noted that 35 of these patients (67%) were men and 21 (40%) had chronic illness. In the cohort of 78 patients reported by Liu (Chin Med J 2020, see ***below***), the patients in the progression group were also older than those in the disease improvement/stabilization group (66 [51, 70] vs. 37 [32, 41] years, U = 4.932, P = 0.001).

Chen (BMJ 2020, see ***below***) analysed the profile of 113 patients who died and 161 who recovered with a diagnosis of COVID-19 up to February 28. The median age of deceased patients (68 years) was significantly older than recovered patients (51 years). Male sex was more predominant in deceased patients (83; 73%) than in recovered patients (88; 55%). Chronic hypertension and other cardiovascular comorbidities were more frequent among deceased patients (54 (48%) and 16 (14%)) than recovered patients (39 (24%) and 7 (4%)).

Similarly, Shi (Crit Care 2020, see ***below***) found age, occupation, hypertension (p<0.001 for the comparisons between mild and severe cases), gender and cardiovascular disease (p<0.003) as risk factors.

Zhang (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.26.20028191v1) presented the clinical characteristics of 82 death cases of laboratory-confirmed as SARS-CoV-2 infection in Wuhan. Most of these death cases were male (65.9%). More than half of dead patients were older than 60 years (80.5%) and the median age was 72.5 years. The bulk of death cases had **comorbidity** (76.8%), including hypertension (56.1%), heart disease (20.7%), diabetes (18.3%), cerebrovascular disease (12.2%), and cancer (7.3%).

The retrospective study involving 44 672 confirmed COVID-19 cases reported by the Novel Coronavirus Pneumonia Emergency Response Epidemiology Team in China (Zhonghua Liu Xing Bing Xue Za Zhi 2020, see ***below***; and Wu Jama 2020, see ***below***) described a proportion of 13.8% severe cases and 4.7% critical cases in their database. They reported more severe disease in Wuhan than outside the province of Hubei. The study concluded that the ≥80 years age group had the highest case fatality rate of all age groups at 14.8%. Case fatality rate for males was 2.8% and for females was 1.7%. While patients who reported no comorbid conditions had a case fatality rate of 0.9%, patients with comorbid conditions had much higher rates - 10.5% for those with cardiovascular disease, 7.3% for diabetes, 6.3% for chronic respiratory disease, 6.0% for hypertension, and 5.6% for cancer.

In line with the observations made in China, Porcheddu (J Infect Dev Ctries 2020, see ***below***) observed that fatalities in Italy mostly occurred in the elderly with known comorbidities.

Diabetes

A meta-analysis of studies reporting the prevalence of diabetes among people infected with SARS-CoV-2 and its impact on disease severity or progression was reported by Fadini (J Endocrinol Invest 2020, see ***below***). 12 studies reporting data from 2108 Chinese patients with confirmed SARS-Cov-2 infection yielded an estimate of the prevalence of diabetes of 10.3%. For comparison, the nationwide prevalence of diabetes in China in 2013 was 10.9% overall and 12.3% among people aged 40–59. The authors concluded that diabetes may not increase the risk of SARS-CoV-2 infection, but can worsen the outcome of COVID-19.

Hypertension

Results of a pooled analysis of the scientific literature (available as of March 26) by Lippi (Pol Arch Intern Med 2020, see ***below***) would suggest that hypertension may be associated with an up to 2.5-fold higher risk of severe and fatal COVID-19, especially among older individuals. A brief meta-analysis by Zuin (J Inf 2020, see ***below***) also demonstrated that patients with COVID-19 infection and hypertension have a significant high mortality risk.

Treatment with ACE inhibitors and angiotensin II type-I receptor blockers?

Wu (JAMA Int Med 2020, see ***below***) found that diabetes and hypertension to be more frequent in those who developed ARDS than those who did not. Fang (Lancet Resp Med 2020, see ***below***) noted that the most frequent comorbidities reported in studies of patients with COVID-19 are often treated with angiotensin-converting enzyme (ACE) inhibitors and angiotensin II type-I receptor blockers (ARBs) (even though treatment was not assessed in these published studies), which increase ACE2 expression. The authors therefore hypothesized that such treatment would increase the risk of developing severe and fatal COVID-19 in patients with cardiac diseases, hypertension, or diabetes. Diaz (J Travel Med 2020, see ***below***) developed a similar hypothesis. However, Patel (JAMA 2020, see ***below***) listed some arguments pointing to a very different view of the topic. For instance, there is limited evidence showing ACE2 expression increases in serum or lung after treatment with these drugs. Moreover, the significance of ACE2 expression on COVID-19 pathogenesis and mortality is not specifically known. And there are preclinical data suggesting that increasing ACE2 expression can attenuate SARS-CoV-2-induced lung injury. Cheng, Wang et al. (J Med Vir 2020, see ***below***) and Vaduganathan (NEJM 2020, see ***below***) provided similar arguments, and even suggested the possibility to treat ARDS with recombinant human ACE2 or ARBs. Meng (Em Micr Inf 2020, see ***below***) evaluated the ability of renin-angiotensin inhibitors to protect against COVID-19 in a small cohort of 42 patients with hypertension. The authors concluded in a protective effect of ACE inhibitors and ARBs on the severity of the disease. A study by Feng (Am J Respir Crit Care Med 2020, see ***below***), which included 476 patients, found a significant difference in ACE inhibitors/ARBs usage among patients with different disease severity. Compared with severe and critical groups, there were more patients taking ACE inhibitor/ARB in the moderate disease group. This observation may seem to confirm the data by Meng. However only few patients in this study used ACE inhibitor/ARB treatment (33/476), suggesting that more data are still required to draw firm conclusions on this topic.

Chronic kidney disease

Another metaanalysis by Henry (Int Urol Nephrol 2020, see ***below***) included four studies, corresponding to 1389 COVID-19 patients, among which 273 (19.7%) were classified as having severe disease. No study individually found chronic kidney disease as significant clinical predictor of severe COVID-19. However, when data of individual studies were pooled, a significant association of chronic kidney disease with severe COVID-19 was observed, with no relevant heterogeneity [OR 3.03 (95% CI 1.09–8.47), I2 = 0.0%, Cochran's Q, p = 0.84].

Cardiovascular diseases

Similarly, Ruan (Intensive Care Med 2020, see ***below***) conducted a retrospective multicenter study of 68 death cases and 82 discharged cases with laboratory-confirmed infection. The authors found a significant difference in age

between the death group and the discharge group ($p < 0.001$) but no difference in the sex ratio ($p = 0.43$). A total of 63% (43/68) of patients in the death group and 41% (34/82) in the discharge group had underlying diseases ($p = 0.0069$). Patients with cardiovascular diseases had a significantly increased risk of death when infected with SARS-CoV-2 ($p < 0.001$). A total of 16% (11/68) of the patients in the death group had secondary infections vs. 1% (1/82) of the patients in the discharge group ($p = 0.0018$).

Cancer

From the analysis of a small cohort of 28 cancer patients, Zhang (Ann Oncol 2020, see ***below***) reported a case-fatality rate of COVID-19 reaching 28.6%.

Liang (Lancet Oncol 2020, see ***below***) reported that patients with cancer have a higher risk of severe events (a composite endpoint defined as the percentage of patients being admitted to the intensive care unit requiring invasive ventilation, or death) compared with patients without cancer (seven [39%] of 18 patients vs 124 [8%] of 1572 patients; Fisher's exact p=0·0003).

Clinical prediction models

As the vast majority of countries have limited testing resources, case identification tools could play a crucial role in containment and mitigation strategies. Various studies have already described attempts at generating clinical prediction models for COVID-19. As reviewed by Wynants (BMJ 2020, see ***below***), three models were identified for predicting hospital admission from pneumonia and other events in the general population; 18 diagnostic models for detecting COVID-19 infection (13 were machine learning based on computed tomography scans); and 10 prognostic models for predicting mortality risk, progression to severe disease, or length of hospital stay. Only one study used patient data from outside of China. The most reported predictors of presence of covid-19 in patients with suspected disease included age, body temperature, and signs and symptoms. The most reported predictors of severe prognosis in patients with covid-19 included age, sex, features derived from computed tomography scans, C reactive protein, lactic dehydrogenase, and lymphocyte count. C index estimates (which provide an estimate of the ability of the model to discriminate) ranged from 0.73 to 0.81 in prediction models for the general population (reported for all three models), from 0.81 to more than 0.99 in diagnostic models (reported for 13 of the 18 models), and from 0.85 to 0.98 in prognostic models (reported for six of the 10 models). All studies were rated at high risk of bias, mostly because of non-representative selection of control patients, exclusion of patients who had not experienced the event of interest by the end of the study, and high risk of model overfitting. Reporting quality varied substantially between studies. Similarly, Hooli (Clin Inf Dis 2020, see ***below***) questioned the reproducibility of four COVID-19 case prediction models presented in another study.

Distribution

A disease situation dashboard is available on the WHO website, which presents the number of confirmed cases globally over time, cases in China by provinces, regions and cities, as well as confirmed cases outside China by country (http://who.maps.arcgis.com/apps/opsdashboard/index.html#/c88e37cfc43b4ed3baf977d77e4a0667).

In addition, the Johns Hopkins University developed its own dashboard to visualize and track the reported cases of COVID-19 on a daily timescale (Dong Lancet Infect Dis 2020, see ***below***). The complete set of data is downloadable as a google sheet (https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6). The case data visualized is collected from various sources, including WHO, U.S. CDC, ECDC China CDC (CCDC), NHC and DXY. DXY is a Chinese website that aggregates NHC and local CCDC situation reports in near real-time, providing more current regional case estimates than the national level reporting organizations are capable of, and is thus used for all the mainland China cases reported in the dashboard (confirmed, suspected, recovered, deaths). U.S. cases (confirmed, suspected, recovered, deaths) are taken from the U.S. CDC, and all other country (suspected and confirmed) case data

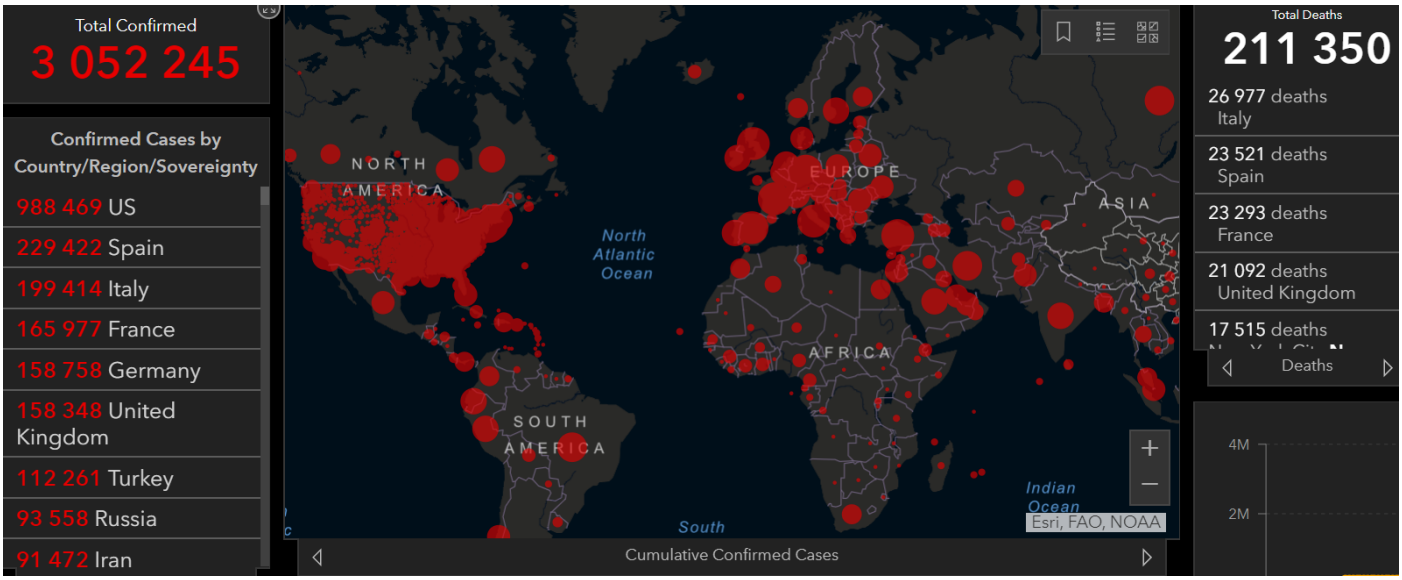
is taken from the corresponding regional health departments. A snapshot of this dashboard data as of April 28 2020 12:00 CET is presented below (Figure 12).

Importantly, Koh (Ann Acad Med Singapore 2020, see ***below***) highlighted the multiple issues affecting the accuracy of COVID-19 case counts.

A serious issue highlighted by Lau (J Microbiol Immunol Infect 2020, see ***below***) relates to inconsistencies in reporting COVID-19 cases. The authors presented preliminary data indicating that countries with lower Health Access Quality-index may either underreport COVID-19 cases or are unable to adequately detect them. Another problem relates to variability in the case definitions used for reporting (see Case definition ***above***). A change in the case definition in China in February, for instance, led to a spike in the reported figures (https://www.sciencemediacentre.org/expert-reaction-to-the-latest-change-in-case-definitions-in-china-for-covid-19/).

Boëlle (EuroSurv 2020, see ***below***) indicated that several French regions where COVID-19 has been reported currently showed a renewed increase in ILI cases in the general practice-based Sentinelles network. The number of excess cases by region from 24 February to 8 March 2020 was computed and a correlation found with the number of reported COVID-19 cases so far. The data suggest larger circulation of SARS-CoV-2 in the French population than apparent from confirmed cases.

Figure 12 Snapshot of the Johns Hopkins University dashboard



HealthMap has made an interactive map for SARS-CoV-2 available at https://www.healthmap.org/covid-19/. It offers near-real-time geolocated updates from various sources to better understand the progression of the pandemic. Healthmap is a team of researchers, epidemiologists and software developers at Boston Children's Hospital founded in 2006, utilizing online informal sources for disease outbreak monitoring and real-time surveillance of emerging public health threats.

Of note, WHO issued guidance to member states on the implementation of global surveillance of COVID-19 (https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov). The objectives of this global surveillance are to monitor trends of the disease where human to human and/or zoonotic transmission occurs; rapidly detect new cases in countries where the virus is not circulating; provide epidemiological information to conduct risk assessment at the national, regional and global level; and provide epidemiological information to guide response measures.

Desjardins (Appl Geogr 2020, see ***below***) utilized a prospective space-time scan statistic to detect emerging clusters of COVID-19 in the United States at the county level. This prospective approach can be useful for state and local health departments to monitor the outbreaks in a timely fashion. The system adds updated COVID-19 counts and reruns the statistic to identify new emerging clusters; while also tracking the previously detected clusters to determine if they are growing or shrinking in magnitude. Doing so can help determine if current mitigation and isolation techniques are effective at curbing the spread of COVID-19.

Factors impacting the distribution of the epidemic

A study by Yao (Eur Resp J 2020, see ***below***) aimed to determine the association of meteorological factors with transmission of COVID-19. Associations of meteorological factors (including temperature, relative humidity and UV radiation) with the spread ability of COVID-19 in various Chinese cities (from early Jan to early March) were analysed. The study did not support the hypothesis that high temperature and UV radiation can reduce the transmission of COVID-19. However, a study by Liu (Sci Total Environ 2020, see ***below***) concluded that meteorological factors play an independent role in the COVID-19 transmission after controlling population migration. Local weather condition with low temperature, mild diurnal temperature range and low humidity likely favour the transmission.

Martelletti (SN Compr Clin Med 2020, see ***below***) showed how the Italian Northern Regions, which have been the most affected by COVID-19, are also those with a high amount of atmospheric particulate matter (PM10 and PM2.5) going above the standard limit of 50 µg/m3 per day in the month of February 2020. This relationship was also illustrated by comparing the nitrogen dioxide emissions and the COVID-19 case fatality in Northern Italy in January 2020. However, epidemiological studies in multiple geographic regions affected by the Covid-19 pandemic remain to be conducted to confirm the association with air pollution.

Arias-Reyes (Respir Physiol Neurobiol. 2020, see ***below***) suggested a lower incidence of COVID-19 in people living at high altitude (above 3000m from sea level).

A MMWR report identified geographic differences in numbers of COVID-19 cases and deaths, cumulative incidence, and changes in incidence (CDC COVID-19 Response Team MMWR Morb Mortal Wkly Rep 2020 April, see ***below***). These were interpreted as likely reflecting a combination of jurisdiction-specific epidemiologic and population-level factors, including 1) the timing of COVID-19 introductions; 2) population density; 3) age distribution and prevalence of underlying medical conditions among COVID-19 patients; 4) the timing and extent of community mitigation measures; 5) diagnostic testing capacity; and 6) public health reporting practices. The authors concluded that monitoring jurisdiction-level numbers of COVID-19 cases, deaths, and changes in incidence is critical for understanding community risk and making decisions about community mitigation, including social distancing, and strategic health care resource allocation.

In terms of research activities, various modelling studies analyse available information and make attempts at forecasting future spread of the disease (see ***Modelling key characteristics of the epidemic*** below).

Virus detection in the environment

Kampf (J Hosp Infect 2020, see ***below***) reviewed the literature on the persistence of human and veterinary coronaviruses on inanimate surfaces as well as inactivation strategies with biocidal agents used for chemical disinfection, e.g. in healthcare facilities. This analysis revealed that human coronaviruses such as SARS and MERS CoVs or endemic human CoVs can persist on inanimate surfaces like metal, glass or plastic for up to 9 days, but can be efficiently inactivated by surface disinfection procedures with 62-71% ethanol, 0.5% hydrogen peroxide or 0.1% sodium hypochlorite within 1 minute. Other biocidal agents such as 0.05-0.2% benzalkonium chloride or 0.02% chlorhexidine digluconate are less effective.

Similarly, Yeo (Lancet Gastroenterol Hepatol 2020, see ***below***) indicated that observations made with SARS and MERS CoVs support a relatively good viability of these viruses on surfaces depending on temperature and humidity. SARS-CoV RNA was found in the sewage water of two hospitals in Beijing treating patients with SARS. When SARS-CoV was seeded into sewage water obtained from the hospitals in a separate experiment, the virus was found to remain infectious for 14 days at 4°C, but for only 2 days at 20°C.

A report by Ong (JAMA 2020, see ***below***) described the detection of virus RNA in the environment of 3 COVID-19 cases in isolation in Singapore. Samples from the environment of one of the patients yielded positive results by RT-PCR, with 13 (87%) of 15 room sites (including air outlet fans) and 3 (60%) of 5 toilet sites (toilet bowl, sink, and door handle) positive. The patient had upper respiratory tract involvement with no pneumonia and had 2 positive stool samples for SARS-CoV-2 on RT-PCR. Of note, only one personal protective equipment (PPE) swab, from the surface of a shoe front, was positive. All other PPE swabs were negative. All air samples were negative. In a subsequent study, the same authors (Ong Infect Control Hosp Epidemiol 2020, see ***below***) conducted a one-day PPE sampling study on 30 HCWs (doctors, nurses, and cleaners) caring for 15 confirmed SARS-CoV-2 infected patients with varying characteristics (i.e. day of illness, presence/absence of symptoms, RT-PCR Ct value). None was requiring ventilatory support and no aerosol generating procedures were carried out prior to or during sampling. Median time spent in the patient's room was 6 minutes for activities ranging from casual contact (e.g. administering medications, cleaning) to closer contact (e.g. physical examination, collection of respiratory samples). All samples (swabs from the entire front of goggles, front surface of N95 respirator, and front surface of shoes) were negative.

Environmental surveillance was also performed by Cheng (Inf Contr Hosp Epidem 2020, see ***below***) in a patient with viral load of $3.3x10^6$ copies/ml (pooled nasopharyngeal/ throat swab) and $5.9x10^6$ copies/ml (saliva) respectively. SARSCoV-2 was revealed in 1 (7.7%) of 13 environmental samples, but not in 8 air samples collected at a distance of 10 cm from patient's chin with or without wearing a surgical mask.

Another important study was conducted by Guo in a hospital in Wuhan (Em Inf Dis 2020, see ***below***) and showed that SARS-CoV-2 was widely distributed in the air and on object surfaces, implying a potentially high infection risk for medical staff and other close contacts. The environmental contamination was greater in the ICU than in the GW. Moreover, SARS-CoV-2 aerosol distribution characteristics indicated that the transmission distance of SARS-CoV-2 might be 4 m. As of March 30, no staff members at this hospital had been infected with SARS-CoV-2, indicating that appropriate precautions could effectively prevent infection. In addition, these findings suggest that home isolation of persons with suspected COVID-19 might not be a good control strategy.

A study by Wang (Int J Inf Dis 2020, see ***below***) did not detect SARS-CoV-2 RNA among the 36 objects surface samples and 9 staffs PPE samples in isolation wards. Sewage samples were positive from inlets of the sewage disinfection pool, but negative from the outlet of the last sewage disinfection pool. Moreover, no viable virus was detected by culture. The monitoring data in this study suggested that strict disinfection and hand hygiene measures could decrease the hospital-associated COVID-19 infection risk of the staffs in isolation wards.

In experimental conditions, van Doremalen (NEJM 2020, see ***below***) found that SARS-CoV-2 remained viable in aerosols for at least 180 minutes, with a reduction in infectious titer 3 hours post-aerosolization from $10^{3.5}$ to $10^{2.7}$ CID50/L (mean across three replicates). This reduction in viable virus titer was relatively similar to the reduction observed in aerosols containing SARS-CoV-1. The virus was most stable on plastic and stainless steel. Viable virus could be detected up to 72 hours post application, though by then the virus titer was greatly reduced (polypropylene from $10^{3.7}$ to $10^{0.6}$ TCID50/mL after 72 hours, stainless steel from $10^{3.7}$ to $10^{0.6}$ TCID50/mL after 48 hours).

Patient management

WHO issued a document intended for clinicians taking care of hospitalised adult and paediatric patients with severe acute respiratory infection (SARI) when a SARS-CoV-2 infection is suspected **(**https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected**).** It is not meant to replace clinical judgment or specialist consultation but rather to strengthen clinical management of these patients and to provide up-to-date guidance. The document addresses the following topics:

- Triage: recognize and sort patients with SARI
- Immediate implementation of appropriate infection prevention and control (IPC) measures
- Early supportive therapy and monitoring
- Collection of specimens for laboratory diagnosis
- Management of hypoxemic respiratory failure and acute respiratory distress syndrome (ARDS)
- Management of septic shock
- Prevention of complications
- Specific anti-COVID-19 treatments
- Special considerations for pregnant patients.

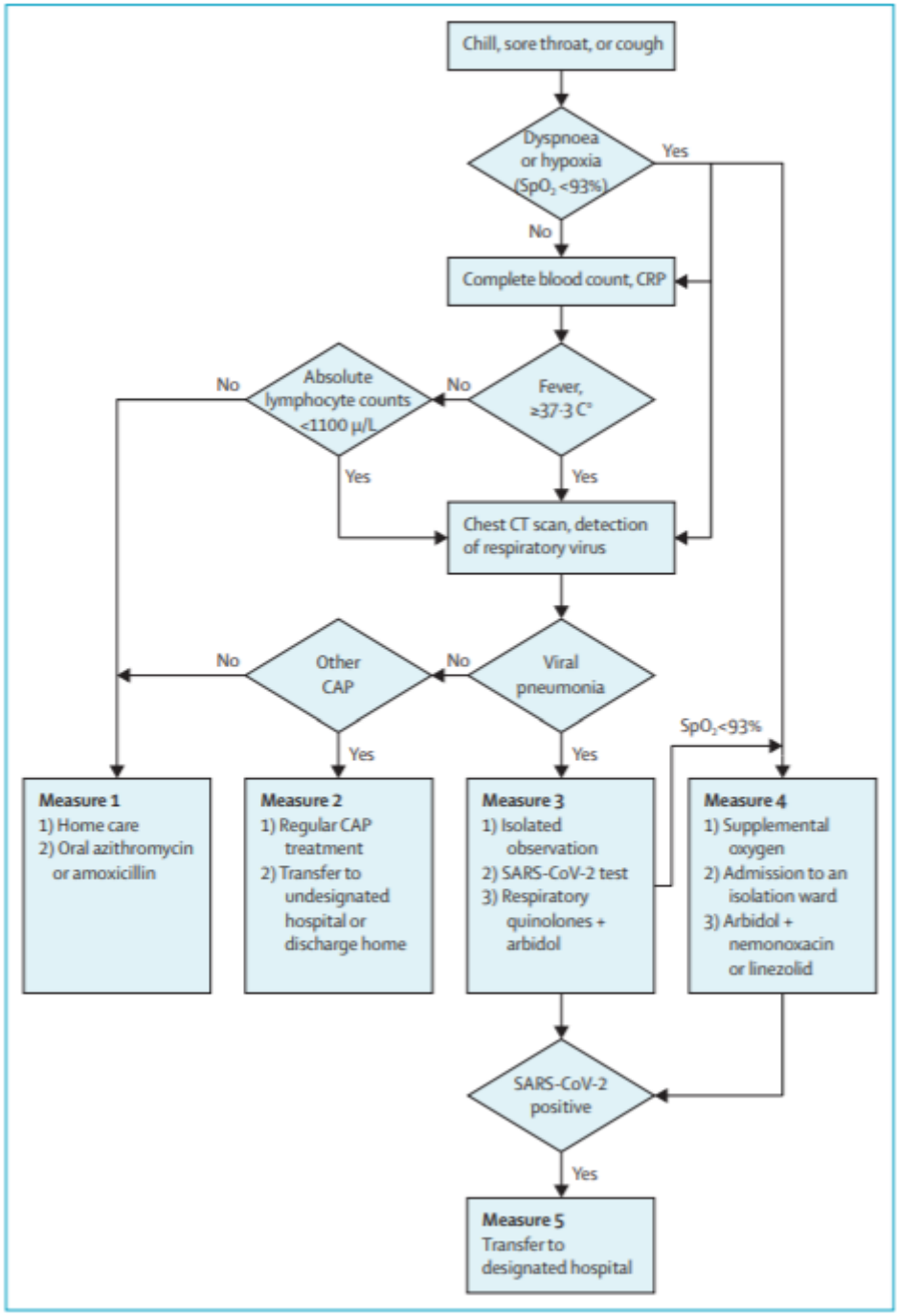
An increasing number of reports describe the disease course and clinical management of patients in China as well as in other countries.

Triage and patient flow

A publication by Zhang (Lancet Resp Med 2020, see ***below***) indicates that one effective strategy for disease control in Wuhan was the establishment of fever clinics for triaging patients. The clinical strategies that were used in these adult fever clinics for COVID-19 management is illustrated by the flowchart presented in Figure 13.

Many aspects of this algorithm would not be feasible in developing countries setting, as chest CT, differential blood counts, and CRP testing are not available. Ayebare (Lancet Resp Med 2020, see ***below***) proposed a modified COVID-19 screening algorithm for use in resource-limited settings that do not have established local transmission.

Figure 13 Flow chart for treatment of 2019 novel coronavirus disease in fever clinics in Wuhan China (CRP=C-reactive protein. CAP=Community-acquired pneumonia. SARS-CoV-2=severe acute respiratory syndrome corona virus 2)



Hu (Acad Emerg Med 2020, see ***below***) provided a first exploration on 2 rapid scoring systems for critical ill patients with COVID-19, the Modified Early Warning Score (MEWS) and Rapid Emergency Medicine Score (REMS). The authors concluded that the REMS could provide emergency clinicians with an effective adjunct risk stratification tool for critical ill patients with COVID-19, especially for the patients aged<65 years. The effectiveness of REMS for screening these patients is attributed to its high negative predictive value.

Current treatment practices

Wang, Chen et al. (Biosci Tr 2020, see ***below***) reported on the diagnosis and treatment of four patients with mild or severe COVID-19 pneumonia. All patients received antiviral treatment, including lopinavir/ritonavir (Kaletra®, lopinavir 400 mg/ritonavir 100 mg, q12h, po), arbidol (0.2 g, tid, po), and Shufeng Jiedu Capsule (2.08 g, tid, po). The duration

of antiviral treatment was 6-15 days. In addition, all patients were all given antibiotic treatment and started on supplemental oxygen, delivered by nasal cannula after admission to hospital.

Liu (Crit Care 2020, see ***below***) reported that patient management in Shenzhen was largely supportive, including intubation, early prone positioning, neuromuscular blockade, and extracorporeal membrane oxygenation (ECMO) according to the recommendations updated by China's National Health Committee. Low-dose systematic corticosteroids, lopinavir/ritonavir, and atomization inhalation of interferon were encouraged.

Murthy (JAMA 2020, see ***below***) noted that evidence-based treatment guidelines for ARDS should be followed, including conservative fluid strategies for patients without shock following initial resuscitation, empirical early antibiotics for suspected bacterial co-infection until a specific diagnosis is made, lung-protective ventilation, prone positioning, and consideration of extracorporeal membrane oxygenation for refractory hypoxemia.

Wang (Lancet 2020, see ***below***) reported on the classification of COVID-19 patients in 3 types for effective triage in a hospital in Wuhan. Patients with pneumonia were classified as type A. Basic treatments were provided, such as antivirals, antibiotics, oxygen therapy, and glucocorticoids. Type B patients had disease accompanied by serious comorbidities. Their pneumonia was managed and specific treatment plans were developed, including antihypertensives, hypoglycaemic therapy, and continuous renal replacement therapy. Critically ill patients were classified as type C. Attention was paid to organ function in these patients and necessary protective measures, including mechanical ventilation, glucocorticoids, antivirals, symptomatic treatments, and anti-shock therapy.

Based on the experience with 631 confirmed cases of COVID-19 (with a portion of critically ill patients whose ages ranged from 9 months to 96 years old) Sun (Ann Intensive Care 2020, see ***below***) reported a cure rate of confirmed cases of 96.67%in Jiangsu Province, far exceeding that of national Chinese data. The authors noted that essential strategies to improve outcomes consist of early detection of high-risk and critically ill patients. In Jiangsu Province, critical care was shifted forward. All COVID-19 patients were screened twice every day and respiratory rate (RR), heart rate (HR), SpO2 (room air) were monitored regularly. Once SpO2 < 93%, RR > 30/min, HR > 120/min or any signs of organ failure were observed, patients would be transferred to ICU. Intervention to prevent the progression of disease were then three-fold: (1) For patients with ARDS or pulmonary extensive effusion in CT scan, high-flow nasal cannula oxygen therapy or non-invasive mechanical ventilation was used to maintain positive end expiratory pressure to prevent alveolar collapse even if some of these patients did not have refractory hypoxemia. (2) Restrictive fluid resuscitation under the premise of adequate tissue perfusion was performed to relieve pulmonary oedema. (3) Awake prone position was attempted in patients which showed significant effects in improving oxygenation and pulmonary heterogeneity.

Duca (Emerg Med Pract. 2020, see ***below***) presented the Brescia-COVID Respiratory Severity Scale (BCRSS)/Algorithm, a step-wise approach to managing patients with confirmed/presumed COVID-19 pneumonia. The tool is being used in Italy for assessment, trending, and treatment recommendations. It has not been externally validated.

A review paper by Nicola (Int J Surg 2020, see ***below***) also provided an interesting update on COVID-19 patient management. In addition, more than twenty nursing experts in China developed a consensus on holistic nursing care of patients with severe COVID-19, which included nursing assessment, nursing priorities, nursing goals, and 13 key points of nursing such as nursing of oxygen therapy and respiratory nursing (Int J Nurs Sci 2020, see ***below***).

Respiratory support

To reduce respiratory symptoms and improve prognosis, respiratory support is the most important means of life support, and non-invasive respiratory support systems, including various conventional oxygen therapies, non-invasive positive pressure ventilation (NPPV), and high-flow nasal cannula (HFNC), are most commonly used (Xia Chin Med J 2020, see ***below***). However, their efficacy and safety remain unclear, and whether they increase the risk of aerosol

dispersion and disease transmission is particularly controversial (see Safety of procedures ***below***, and Ñamendys-Silva Lancet Respir Med 2020, see ***below***). The retrospective epidemiological study of 99 COVID-19 pneumonia patients in China revealed that NPPV is the most commonly used mechanical ventilation method for acute respiratory failure, with reported rates of using non-invasive and invasive mechanical ventilation of 13% and 4%, respectively. For strictly selected early-stage patients with mild-to-moderate (partial pressure of arterial oxygen [PaO2]/fraction of inspired oxygen [FiO2] > 200 mmHg) hypoxic respiratory failure and especially for units with limited numbers of invasive ventilators, it has been recommended that NPPV be attempted for short periods of time (1-2 hours) and to intubate immediately if no improvement is observed.

Of note, MacLaren (JAMA 2020, see ***below***) commented on the WHO interim guidelines making general recommendations for treatment of ARDS in the context of the COVID-19 epidemic, including that consideration be given to referring patients with refractory hypoxemia to expert centres capable of providing ECMO. ECMO being a resource-intensive, highly specialized, and expensive form of life support with the potential for significant complications, he recommended limiting support with ECMO to the most critically ill patients in regions with the extensive resources required to provide this therapy. In less well-resourced countries, his hypothesis is that many more lives will be saved by ensuring oxygen and pulse oximetry are widely available. Li (Chin Med J 2020, see ***below***) reported experience compared with that in patients receiving only conventional respiratory care, the fatality of those who had received ECMO was significantly lower (100% vs. 65%). However, a review by Henry (J Crit Care 2020, see ***below***) raised questions about real utility of ECMO in COVID-19 patients and concluded that further research is urgently needed.

Treatment of coagulopathy

The use of heparin in COVID-19 has been recommended by some expert consensus due to the risk of disseminated intravascular coagulation and venous thromboembolism. However, the efficacy of such treatment remains to be validated. A study in 449 patients with severe COVID-19, 99 of them receiving heparin for 7 days or longer suggested that anticoagulant therapy mainly with low-molecular weight heparin appears to be associated with better prognosis in severe COVID-19 patients meeting sepsis-induced coagulopathy criteria or with markedly elevated D-dimer (Tang J Thromb Haemost 2020, see ***below***). The 28-day mortality of heparin users was lower than that in non-users when considering patients with sepsis-induced coagulopathy score ≥4 (40.0% vs 64.2%, P=0.029), or D-dimer > 6-fold the upper limit of normal range (32.8% vs 52.4%, P=0.017).

Treatment options in pregnancy

Recent studies have identified remdesivir and chloroquine as strong candidate drugs for the treatment of COVID-19 (see ***Antiviral drugs*** below). Remdesivir appears to be safe in human pregnancies (Mulangu NEJM 2019, see ***below***) Although chloroquine and its metabolites cross the placenta, it may be safely used in all trimesters of pregnancy with no increased risk of adverse perinatal outcomes. However, it is worthwhile noting that chloroquine is a drug with a large volume of distribution and pharmacokinetic studies have shown significantly lower plasma drug concentrations in pregnancy (Karunajeewa Antimicr Ag Chemother 2010, see ***below***). Lopinavir-ritonavir have also shown some benefit in management of COVID-19. Lopinavir-ritonavir is not studied in context of pregnancy complicated with respiratory infection, however in HIV-positive pregnancies, no increased risk of foetal anomalies, preterm birth or low birth weight infants was observed (Tookey BMC Infect Dis 2016, see ***below***). Conversely, ribavirin and baricitinib are teratogenic (Winthrop Nat Rev Rheumatol 2017, see ***below***; Kochhar Toxicol Appl Pharmacol 1980, see ***below***). Use of ribavirin has led to miscarriages, craniofacial and limb defects in animal studies and should be avoided, especially in early pregnancy.

In general, use of corticosteroids is not recommended as it may delay the virus clearance from the body. A common practice in obstetrics is to give corticosteroids for foetal lung maturity to those at risk of delivering prematurely. Travers (BMJ 2017, see ***below***) demonstrated that the lowest gestations receive the largest benefit from

corticosteroids. Indeed, the number of mothers needed to treat with corticosteroids to prevent one neonatal death is six at 23 to 24 weeks but can increase to 798 women at 34 weeks. During this pandemic, it is necessary to balance out the possible risks and benefits of corticosteroid use. McIntosh (Am J Perinatal 2020, see ***below***) has examined the maternal risks and foetal benefits and recommends that no women COVID-19 positive or person under investigation (PUI) receive corticosteroids beyond 32 weeks.

Use of drugs in pregnant women needs to be on the basis of solid evidence. Clinical trials are needed to prove the effectiveness of drugs and the effects on the foetus. WHO advises caution and careful risk-benefit analysis before using investigational therapeutic agents in pregnant women outside clinical trials and WHO does not recommend the use of corticosteroids for COVID-19.

Ethical issues

An ethically sound framework has been outlined in the Hastings Center's 3-tiered approach to a pandemic; namely, the duty to plan, the duty to safeguard, and the duty to guide. Furthermore, in the U.S.A. the landmarks proposed by the American College of Surgeons of transparency, advocacy, and commitment to support all those affected directly or indirectly clarify a way forward. Multiple ethical challenges have been raised by the COVID-19 pandemic. A few reports have made proposals to address them. For instance, Kramer (J Am Coll Surg 2020, see ***below***) provided a few recommendations based on the concepts highlighted above to questions such as "Do providers have the right to refuse to treat a COVID-19 positive patient, or do they have a professional duty to treat the patient, no matter how high the personal risk?" . The question of " How do we allocate scarce resources such as ICU beds, ventilators, and certain medications?" has also been addressed by Manelli (J Med Ethics 2020, see ***below***), who insisted on the relevance of a medical ethics perspective that does not place the burden of care and choice solely on physicians.

Diagnostics

Interim guidance to laboratories and stakeholders involved in laboratory testing of patients who meet the definition of suspected case of pneumonia associated with SARS-CoV-2 has been provided by WHO (https://www.who.int/publications-detail/laboratory-testing-for-2019-novel-coronavirus-in-suspected-human-cases-20200117). Until validated diagnostic tests become available, the goals of diagnostic testing are to detect conventional causes of pneumonia early, to support disease control activities, and to work with reference laboratories that can perform pan-coronavirus detection and directed sequencing.

WHO has taken a three-pronged approach to enhance diagnostic capacity for COVID-19:

- Forming a network of specialized referral laboratories with demonstrated expertise in the molecular detection of coronaviruses. These international labs can support national labs to confirm COVID-19 cases and troubleshoot their molecular assays;
- Strengthening national capacity for detection of COVID-19 so that diagnostic testing can be performed rapidly without the need for overseas shipping. One way this has been achieved is through working with existing global networks for detection of respiratory pathogens such as, notably, the National Influenza Centers that support the Global Influenza Surveillance and Response System;
- Ensuring test availability. This has involved a) screening of SARS-CoV-2 PCR protocols from academic laboratories for validation data (e.g. limits of detection, specificity), b) looking for sequence alignment of established commercial coronavirus assays (e.g. SARS) to see if any were likely to be able to detect 2019-nCoV with high sensitivity, and c) working with commercial and non-commercial agencies with capacity to manufacture and distribute newly-developed SARS-CoV-2 PCR assays.

Specimen

Lower respiratory specimens were soon considered likely to have a higher diagnostic value than upper respiratory tract specimens for detecting SARS-CoV-2 infection. WHO recommended that lower respiratory specimens such as sputum, endotracheal aspirate, or bronchoalveolar lavage be collected for SARS-CoV-2 testing where possible (https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov)). However, Yang (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.11.20021493v1) noted that no data on the difference of viral shedding between the upper and lower respiratory tract specimens was available. He reported that while viral RNAs could be detected in all the lower respiratory tract of severe cases, the situation was different for mild cases. Sputum specimen were recommended as most accurate for laboratory diagnosis of COVID-19, followed by nasal swabs.

A study by Zou (NEJM 2020, see ***below***) analysed the viral load in nasal and throat swabs obtained from 17 symptomatic patients in relation to day of onset of any symptoms. Higher viral loads were detected soon after symptom onset, with higher viral loads detected in the nose than in the throat. This analysis suggests that the viral nucleic acid shedding pattern of patients infected with SARS-CoV-2 resembles that of patients with influenza and appears different from that seen in patients infected with SARS-CoV.

A small study in 12 hospitalized patients suggested the feasibility of using self-collected saliva as specimen for diagnostic purposes (To J Vir 2020, see ***below***).

While describing 2 cases, Han (Lancet Inf Dis 2020, see ***below***) suggested that sputum induction might be more helpful than throat swabs for the detection of SARS-CoV-2 RNA in convalescent patients.

Zhang (J Med Virol 2020, see ***below***) presented PCR testing results on stool and oropharyngeal swabs specimens from 14 patients.

A larger study analysed a total of 1070 specimens of different types that were collected from 205 patients with COVID-19 (Wang JAMA 2020, see ***below***). Bronchoalveolar lavage fluid specimens showed the highest positive rates (14 of 15; 93%), followed by sputum (72 of 104; 72%), nasal swabs (5 of 8; 63%), fibrobronchoscope brush biopsy (6 of 13; 46%), pharyngeal swabs (126 of 398; 32%), faeces (44 of 153; 29%), and blood (3 of 307; 1%). None of the 72 urine specimens tested positive.

Khoubnasabjafari (Bioanalysis 2020, see ***below***) suggested exhaled breath condensate (EBC) as a sample for RT-PCR. EBC is a condensed form of small droplets of lung lining fluid which is normally exhaled and contains a variety of components from small ions to proteins and organelles, even viruses, fungi and bacteria. Technical tips for improving the quality and quantity of extracting nucleic acid from EBC samples have been reported. The same procedure with some modifications could be used to detect the genome of SARS-CoV-2 by RT-PCR. EBC samples could be easily collected using a simple cold trap, commercially available EBC sampling device (such as EcoScreen® or RTube®) or even using a tube passing water-ice mixture. The mechanism of sample collection by these devices is cooling down the temperature of the collection chamber from 0 to -25°C. Collection of EBC is simple, well tolerated by sample donors and no adverse effects have been reported so far, therefore it could be employed for sampling on a large scale to screen COVID-19 suspected patients.

Testing methods

A list of assays commercially available for diagnosis of COVID-19 is updated by FIND (https://www.finddx.org/covid-19/). Assays that are still in development stage are also presented.

Udugama (ASC nano 2020, see ***below***) presented an overview on current techniques such as PCR and CT scans, as well as on emerging diagnostic methods for COVID-19.

Molecular methods

A review by Shen (J Pharm Anal 2020, see ***below***) summarized the currently available detection methods for coronavirus nucleic acid. The paper is short, but provides very clear explanations about the different methods that have been developed.

RT-PCR

Currently used RT-PCR assays

In acute respiratory infection, RT-PCR is routinely used to detect causative viruses from respiratory secretions. Early reports presented various assays for COVID-19 diagnosis. A real-time reverse-transcription PCR (rtRT-PCR) was used to identify SARS-CoV-2 through preliminary and validation detection of its E gene, RNA-dependent RNA polymerase (RdRp) gene, and N gene (Yu Micr Inf 2020, see ***below***). Chu (Clin Chem 2020, see ***below***) reported the development of two 1-step quantitative rtRT-PCR assays detecting the ORF1b and N regions of the viral genome. The primer and probe sets were designed to react with SARS-CoV-2 and its closely related viruses, such as SARS coronavirus. These assays were evaluated using a panel of positive and negative controls and shown to have a dynamic range of at least seven orders of magnitude ($2x10^{-4}$-2000 TCID50/reaction).

Fluorescence-based quantitative PCR kit were rapidly distributed by the Chinese CDC for laboratory confirmation of disease in China. And a whole array of commercial tests became available. Wang (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.12.20022327v1.full.pdf) reported for instance the use of a detection kit (Bioperfectus, Taizhou, China) to detect the ORF1ab gene and the N gene using real-time RT-PCR. Positive results on both the ORF1ab gene and the N gene are required for laboratory confirmation of the disease.

In Europe, the envelope (E)-gene screening test as published by Corman (Euro Surv 2020, see ***below***) has been widely implemented.

Sharfstein (JAMA 2020, see ***below***) and Babiker (Am J Clin Pathol 2020, see ***below***) provided a detailed explanation of the issues faced in the U.S. at the beginning of the epidemic, which delayed COVID-19 PCR testing in the country.

Improving PCR assays

Chan (J Clin Microb 2020, see ***below***) developed a novel real-time RT-PCR assay targeting the RNA-dependent RNA polymerase (RdRp)/helicase (Hel) (COVID-19-RdRp/Hel assay). The assay has a low limit of detection (1.8 TCID50/ml with genomic RNA and 11.2 RNA copies/reaction with in vitro RNA transcripts). It was compared to the RdRp-P2 assay currently used in European laboratories. Among 273 specimens from 15 patients with laboratory-confirmed COVID-19 in Hong Kong, 77 (28.2%) were positive by both the COVID-19-RdRp/Hel and RdRp-P2 assays. The COVID-19-RdRp/Hel assay was positive for an additional 42 RdRd-P2-negative specimens [119/273 (43.6%) vs 77/273 (28.2%), P<0.001], including 29/120 (24.2%) respiratory tract specimens and 13/153 (8.5%) non-respiratory tract specimens. The mean viral load of these specimens was 3.21×10^4 RNA copies/ml (range, 2.21×10^2 to 4.71×10^5 RNA copies/ml). The COVID-19-RdRp/Hel assay did not cross-react with other human-pathogenic coronaviruses and respiratory pathogens in cell culture and clinical specimens, whereas the RdRp-P2 assay cross-reacted with SARS-CoV in cell culture.

Won (ExpNeurobiol 2020, see ***below***) presented a low cost, rapid alternative RT PCR protocol for COVID-19 diagnosis, composed of specimen self-collection by the patient via pharyngeal swab, Trizol-based RNA purification, and SYBR Green-based RT PCR.

Automated platforms

Pfefferle (Euro Surveill 2020, see ***below***) evaluated the performance of a molecular assay for detection of SARS-CoV-2 on a high-throughput platform, the cobas 6800, using the 'open channel' for integration of a laboratory-developed

assay. The authors observed good analytical performance in clinical specimens. The fully automated workflow enabled high-throughput testing with minimal hands-on time, while offering fast and reliable results.

Cepheid announced that it has received Emergency Use Authorization (EUA) from the U.S. FDA for Xpert® Xpress SARS-CoV-2, a rapid molecular diagnostic test for qualitative detection of SARS-CoV-2 (http://cepheid.mediaroom.com/2020-03-21-Cepheid-Receives-Emergency-Use-Authorization-from-FDA-for-Rapid-SARS-CoV-2-Test). The test has been designed to operate on any of Cepheid's automated GeneXpert® Systems, with a detection time of approximately 45 minutes.

Validation data & assay limitations

Xie (Int J Inf Dis 2020, see ***below***) compared nucleic acid amplification testing performed with 3 different fluorescent RT-PCR kits on different samples, including oropharyngeal swab, blood, urine and stool. Nine out of the 19 patients tested were found positive for SARS-CoV-2 using oropharyngeal swab samples, and the virus nucleic acid was also detected in eight of these nine patients using stool samples. None of positive results was identified in the blood and urine samples. Similar data were obtained with the 3 kits.

Of note, a lack of assay sensitivity was reported by Xie (Radiol 2020, see ***below***), who described five patients with SARS-CoV-2 infection who had initial negative RT-PCR results in mouth swabs but typical imaging findings, including ground-glass opacity (5 patients) and/or mixed ground-glass opacity and mixed consolidation (2 patients). All patients were eventually confirmed with SARS-CoV-2 infection by repeated swab tests. Similar cases were reported by various authors:

- Huang (Radiol 2020, see ***below***).
- Winichakoon (J Clin Microb 2020, see ***below***) reported a case of COVID-19 pneumonia diagnosed from bronchoalveolar lavage fluid in Thailand, who initially had negative tests from nasopharyngeal/oropharyngeal swabs.
- A publication by Wang, Kang et al. (J Med Vir 2020, see ***below***) further illustrates the sensitivity limitation of current RT-PCR based diagnosis, previously reported by others. Although the paper does not provide details, the authors described a COVID-19 case not confirmed by SARS-CoV-2 RT-qPCR testing at the first three evaluations within three weeks, before bronchoalveolar lavage fluid was acquired and results from both RT-qPCR and next-generation sequencing (NGS) testing became positive for SARS-CoV-2.
- Ruan (Chin Med J 2020, see ***below***) presented a case with negative RT PCR result until day 11 of disease onset.

Interestingly, a study by Li (J Med Vir 2020: https://onlinelibrary.wiley.com/doi/abs/10.1002/jmv.25786) evaluated the sensitivity of RT-PCR testing on sequential samples. The study illustrated well on one hand the importance of retest for improving detection of positive cases, and on the other hand the instability of results over time in a same patient.

Wang (Clin Chem 2020, see ***below***) showed that the limit of detection (LOD) of the six commercial kits approved in China differ substantially, with the poorest LODs likely leading to false-negative results when RT–PCR is used to detect SARS-CoV-2 infection.

Rhoads (J Clin Microbiol 2020, see ***below***) compared the Abbott ID Now, Diasorin Simplexa, and CDC FDA EUA methods for the detection of SARS-CoV-2 from nasopharyngeal and nasal swabs. The 95% CIs for the positive percent agreement was overlapping for the ID Now and Simplexa assays when using the modified CDC method as the reference standard. The sample size of this study was not large enough to conclude one of these assays had clearly superior or inferior performance for the detection of SARS-CoV-2 from upper respiratory specimens in liquid transport media.

Another report by Moran (J Clin Microbiol 2020, see ***below***) compared results from specimens tested with Cepheid Xpert Xpress SARS-CoV-2 and Roche cobas SARS-CoV-2 assays. Of these 103 specimens, 42 tested positive and 60 tested negative with both systems for agreement of 99%.

A possible technical limitation of current RT-PCR was raised by Fan, Zhang et al. (Chin Med J 2020, see ***below***). The authors evaluated the potential impact of SARS-CoV-2 genome evolution on RT-PCR performance by analysing published primer sets and their match with 77 publicly available whole genome sequences. They found five RT-qPCR primer sets (targeting Orf1ab or N) that may potentially cause false negative results. Targeting the more conserved nsp12 (RdRp) gene was thus recommended.

Tahamtan (Expert Rev Mol Diagn. 2020, see ***below***) provided an overview of the performance issues with RT-PCR. Conclusions were that in case of negative RT-PCR result with clinical features suspicion for COVID-19, especially when only upper respiratory tract samples were tested, multiple sample types in different time points, including from the lower respiratory tract if possible, should be tested. Combination of real time RT-PCR and clinical features especially CT image could facilitate disease management. Proper sampling procedures, good laboratory practice standard, and using high quality extraction and real-time RT-PCR kit could improve the approach and reduce inaccurate results.

Other molecular techniques

Other possible molecular-based detection techniques include reverse transcription loop-mediated isothermal amplification (RT-LAMP), which feasibility for detection of SARS-CoV-2 has been established by various groups.

- Lamb (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.19.20025155v1) demonstrated the feasibility of rapid screening diagnosis completed in under 30 minutes, using Reverse Transcription Loop-Mediated Isothermal Amplification (RT-LAMP) . No validation data have been presented yet. Only simulated patient samples were used, which were created by spiking serum, urine, saliva, oropharyngeal swabs, and nasopharyngeal swabs with a portion of the COVID-19 nucleic sequence.
- Yu (Clin Chem 2020, see ***below***) developed an isothermal LAMP based method for COVID-19, amplifying a fragment of the ORF1ab gene. The assay detected synthesized RNA equivalent to 10 copies of virus. Reaction time varied from 15-40 minutes, depending on the loading of virus in the collected samples. 42/43 patient samples initially diagnosed with RTqPCR showed consistent signal after 40 min incubation with the new assay (97.6% sensitivity).
- Another LAMP method was described by Baek (Em Micr Inf 2020, see ***below***)

Several CRISPR-based diagnostic methods have also been described:

- Hou (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.22.20025460v1) reported the development of an isothermal, CRISPR-based diagnostic. The assay demonstrated a near single-copy sensitivity. It was evaluated on 61 specimen with suspected infection (52 positives) and showed great clinical sensitivity with a shorter turn-around time (40 min) than RT-PCR.
- Proof-of-principle of another CRISPR-based detection method was also described by Curti (on BioRxiv: https://www.biorxiv.org/content/10.1101/2020.02.29.971127v1).
- Broughton (Nat Biotech 2020, see ***below***) reported development of a rapid (<40 min), easy-to-implement and accurate CRISPR-Cas12-based lateral flow assay for detection of SARS-CoV-2 from respiratory swab RNA extracts. The method was validated using clinical samples from patients in the United States, including 36 patients with COVID-19 infection and 42 patients with other viral respiratory infections. The CRISPR-based DETECTR assay provided a 95% positive predictive agreement and 100% negative predictive agreement compared to the US CDC SARS-CoV-2 real-time RT-PCR assay.

Guan (Chin Med J 2020, see ***below***) reported a case with inconsistent fluorescence quantitative-PCR results, for which high-throughput sequencing was used to make a further diagnosis of SARS-CoV-2 infection. Although high-throughput sequencing appears too costly and labour-intensive for routine diagnosis, the authors believe that it can be used for further diagnosis of COVID-19 patients with unclear PCR results under the condition of strict operation and quality control.

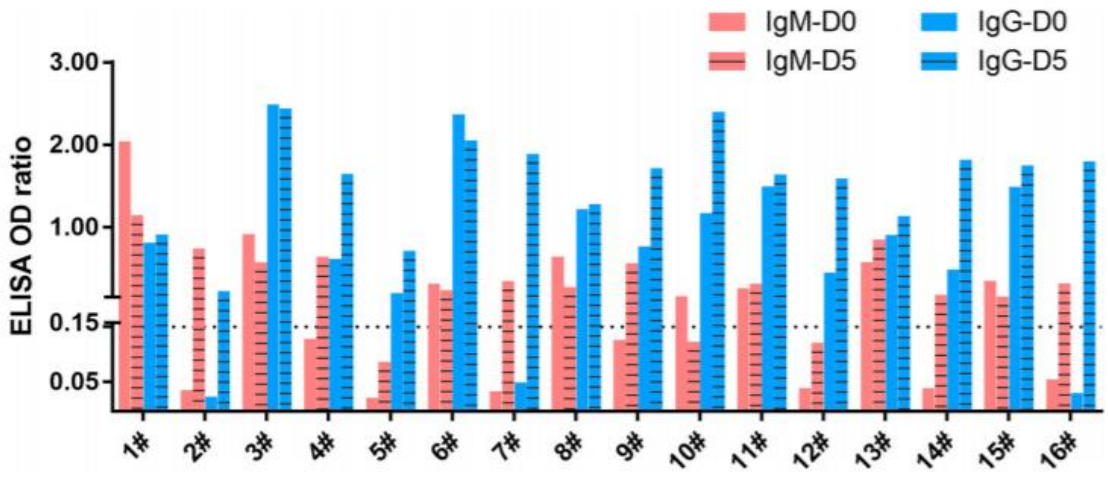
Serological methods

A review paper by Infantino (Isr Med Assoc J 2020, see ***below***) provides an overview on serological diagnostic assays.

ELISA

ELISA protocols for detection of antibodies to SARS-CoV-2 have been described, and data generated by commercial ELISA kits accumulate. For instance, a SARS-CoV-2 IgM and IgG ELISA has been reported by Zhang (Em Micr Inf 2020, see ***below***). The assay is based on recombinant N. A preliminary evaluation was conducted in 16 patients (incl. 3 patients with severe disease). As shown on Figure 14, an increase of specific antibodies was seen in part of the patients as early as by day 5.

Figure 14 Serological detection of SARS-CoV-2. Dashed line indicates cut-off, which was determined based on data from healthy controls (from Zhang Em Micr Inf 2020).



Xiang (manuscript on MedRxiv https://www.medrxiv.org/content/10.1101/2020.02.27.20028787v1) reported the evaluation of 2 serological assays: an IgG and IgM ELISA and a colloidal gold-immunochromatographic assay kit for detection of COVID-19. Using 63 samples for the ELISA and 91 plasma samples for the colloidal gold-immunochromatographic assay, they found a sensitivity of the combined ELISA IgM and ELISA IgG of 55/63 (87.3%), and that of the colloidal gold-immunochromatographic IgM and IgG assay of 75/91 (82.4%). Both methods displayed a specificity of 100%.

Liu (J Clin Micr 2020, see ***below***) reported the evaluation of N and S protein-based IgM and IgG ELISAs in 214 confirmed COVID-19 patients (Table 11.

Table 11 IgM and IgG detection in the 214 serum samples from patients with COVID-19 (from Liu J Clin Micr 2020)

No. (%)	positive both rN- and rS- based ELISA	positive only by rN-based ELISA	positive only by rS-based ELISA	negative both rN- and rS-based ELISA
IgM	137(64.0)	9(4.2)	28(13.1)	40(18.7)
IgG	137(64.0)	13(6.1)	22(10.3)	42(19.6)
IgM and/or IgG	162(75.7)	10(4.7)	14(6.5)	28(13.1)

The sensitivity of the S-based ELISA for IgM detection was significantly higher than that of the N-based ELISA. An increase in the sensitivity of IgM and IgG detection was observed with an increasing number of days post-disease onset. The positive rate of N-based and S-based IgM and IgG ELISAs was less than 60% during the early stage of the illness (day 0-10), and increased after 10 days.

A study by Zhao (Clin Inf Dis 2020, see ***below***) investigated the dynamics of total Ab, IgM and IgG antibody against SARS-CoV-2 in serial blood samples collected from 173 confirmed COVID-19 patients. Testing was performed ELISA kits supplied by Beijing Wantai Biological Pharmacy Enterprise. Antibodies were found in <40% of patients within 1-week since onset, and rapidly increased to 100.0% (Ab), 94.3% (IgM) and 79.8% (IgG) by day-15 after onset. In contrast, RNA detectability decreased from 66.7% (58/87) in samples collected before day-7 to 45.5% (25/55) between day 15 and 39. Combining RNA and antibody detections significantly improved the sensitivity of pathogenic diagnosis for COVID-19.

Okba (Em Inf Dis 2020, see ***below***) presented validation data for in house S and N based ELISAs as well as for a β version of the Euroimmun commercial S1 IgG or IgA ELISAs. In the 3 in-house ELISAs tested, the RBD and N protein ELISAs were more sensitive than S1 ELISA in detecting antibodies in mildly infected patients and showed stronger correlations with PRNT50 titers. Therefore, the authors indicated that detecting antibodies against 2 different antigens might be needed to avoid false-negative results in surveillance studies.

Wang (J Clin Microb 2020, see ***below***) reported that middle-high level of rheumatoid factor-IgM in sera could lead to false-positive reactivity in SARS-CoV-2 IgM GICA (colloidal gold immunochromatography assay) and ELISA assays. The authors suggested that urea dissociation tests would be helpful in reducing such false-positive SARS-CoV-2 IgM results.

Of note, Stadlbauer (Curr Protoc Microbiol 2020, see ***below***) described a detailed protocol for expression of antigens derived from the S protein of SARS-CoV-2 that can serve as a substrate for immunological assays, as well as the protocol of a two-stage ELISA.

Chemiluminescence (CLIA)

Jin (Int J Infect Dis 2020, see ***below***) investigated the diagnostic value of serological test and evolution of test results over time in 43 COVID-19 patients. SARS-CoV-2 IgM and IgG chemiluminescence immunoassay (CLIA) kits from Shenzhen YHLO Biotech Co., Ltd (China) were used, with two antigens of SARS-CoV-2 coated on the magnetic beads of these CLIA assays (N and S proteins). Compared to molecular test, the sensitivity of serum IgM and IgG antibodies to diagnose COVID-19 was 48.1% and 88.9%, and the specificity was 100% and 90.9%. However, IgG positive rate increased till 100% over time.

Padoan (Clin Chem Lab Med 2020, see ***below***) and Lippi (Clin Chem Lab Med 2020, see ***below***) reported on the validation of MAGLUMI 2000 Plus CLIA assay for the measurement of specific IgM and IgG in sera. Results of MAGLUMI IgM and IgG were well aligned with those of Euroimmun Anti-SARS-CoV-2 IgA and IgG, especially concerning the IgG and the cumulative immunoglobulin profile.

Pseudotype neutralization assay

Nie (Emerg Microbes Infect 2020, see ***below***) reported on a pseudovirus neutralization assay for SARS-CoV-2 and its validation. The assay is based on a VSV pseudovirus system. The key parameters for this assay were optimized, including cell types, cell numbers, virus inoculum. With this test, SARS-CoV-2 convalescent patient sera showed high neutralizing potency. The assay showed relatively low coefficient of variations with 15.9% and 16.2% for the intra- and inter-assay analyses respectively.

Rapid test for antibody detection

Li, Yi et al. (J Med Vir 2020, see ***below***) reported the development of a rapid and simple point-of-care lateral flow SARS-CoV-2 immunoassay which can detect IgM and IgG antibodies simultaneously in human blood within 15 minutes. The clinical detection sensitivity and specificity of this test were measured using blood samples collected from 397 PCR-confirmed COVID-19 patients and 128 negative patients at 8 different clinical sites. The overall testing sensitivity reached 88.66% and specificity 90.63%. The assay was evaluated on fingerstick blood samples, as well as serum and plasma from venous blood.

Cassaniti (J Med Vir 2020: https://onlinelibrary.wiley.com/doi/10.1002/jmv.25800) reported a study aimed at validating the VivaDiagTM COVID-19 IgM/IgG Rapid Test lateral flow immunoassay (LFIA) for the rapid diagnosis of COVID-19, in real-life conditions. The performance of VivaDiagTM COVID-19 test was assessed in 50 patients at their first access at emergency room department with fever and respiratory syndrome in comparison with results of nasal swab molecular screening. Sensitivity of the VivaDiagTM COVID-19 IgM/IgG Rapid Test was only 18.4%, specificity was 91.7%, while NPV was 26.2% and PPV was 87.5% in patients enrolled from emergency room department. The assay can thus not be recommended for triage of suspect patients.

Pan (J Inf 2020, see ***below***) compared an immunochromatographic strip assay targeting viral IgM or IgG antibody (Zhuhai Livzon Diagnositic Inc.) to RT-PCR. The sensitivity of ICG assay with IgM and IgG combinatorial detection in nucleic acid confirmed cases were 11.1%, 92.9% and 96.8% at the early (1-7 days after onset), intermediate (8-14 days after onset), and late stage (more than 15 days), respectively. The ICG detection capacity in nucleic acid-negative suspected cases was 43.6%.

Rapid test for antigen detection

According to the company website, Bioeasy (Shenzen, China) has developed 2 different rapid tests for SARS-CoV-2 antigen detection: a Fluorescence test and a GICA colloidal gold enhanced Rapid Test for the qualitative detection of SARS-CoV-2 antigen (http://en.bioeasy.com/product?kind=milk).

Chest CT for COVID-19 detection

Fang (Radiol 2020, see ***below***) reported that in a series of 81 patients, the sensitivity of chest CT was found greater than that of RT-PCR (98% vs 71%, respectively, p<.001). Subjects with initial negative RT-PCR became positive upon retest 1 to 7 days later. Possible reasons for the low efficiency of viral nucleic acid detection may include: 1) immature development of nucleic acid detection technology; 2) variation in detection rate from different manufacturers; 3) low patient viral load; or 4) improper clinical sampling. These results provided first evidence of a possible role for chest CT for screening patients with clinical and epidemiologic features compatible with COVID-19 particularly when RT-PCR testing is negative.

Ai (Radiol 2020, see ***below***) reported a large study further supporting the diagnostic value of chest CT. Of 1014 patients included in the study, 59% had positive RT-PCR results, and 88% had positive chest CT scans. The sensitivity of chest CT in suggesting COVID-19 was 97% based on positive RT-PCR results. In patients with negative RT-PCR results, 75% (308/413) had positive chest CT findings; among them, 48% were considered as highly likely cases, 33% as probable cases. The mean interval time between the initial negative to positive RT-PCR results was 5.1 ± 1.5 days. Moreover, 60% to 93% of cases had initial positive CT consistent with COVID-19 prior (or parallel) to the initial positive RT-PCR results. Interestingly, 42% (24/57) cases showed improvement in follow-up chest CT scans before the RT-PCR results turning negative.

A metaanalysis by Kim (Radiology 2020, see ***below***) assessed the diagnostic performance of chest CT and RT-PCR. The pooled sensitivity was 94% (95% CI: 91%, 96%; I2=95%) for chest CT and 89% (95% CI: 81%, 94%; I2=90%) for RT-PCR. The pooled specificity was 37% (95% CI: 26%, 50%; I2=83%) for chest CT. For chest CT scans, the positive predictive value (PPV) ranged from 1.5% to 30.7%, and the negative predictive value (NPV) ranged from 95.4% to 99.8%. For RT-PCR, the PPV ranged from 47.3% to 96.4%, while the NPV ranged from 96.8% to 99.9%. The sensitivity of CT was affected by the distribution of disease severity, the proportion of patients with comorbidities, and the proportion of asymptomatic patients (all $p < 0.05$). Interestingly, the sensitivity of RT-PCR was negatively associated with the proportion of elderly patients ($p = 0.01$)

Deep-learning analysis methods

Wang (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.14.20023028v2) suggested the application of Artificial Intelligence's deep learning methods to extract COVID-19's specific graphical features from radiographical

changes in CT images. The internal validation of the new method achieved a total accuracy of 82.9% with specificity of 80.5% and sensitivity of 84%. The external testing dataset showed a total accuracy of 73.1% with specificity of 67% and sensitivity of 74%. Subsequently, a similar deep learning approach developed by Xu (on ArXiv: https://arxiv.org/abs/2002.09334) was reported to yield an overall diagnostic accuracy of 86.7 %.

Chen (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.25.20021568v1) even suggested a better performance of this approach. His model achieved a per-patient sensitivity of 100%, specificity of 93.55%, accuracy of 95.24%, PPV of 84.62%, and NPV of 100%; a per-image sensitivity of 94.34%, specificity of 99.16%, accuracy of 98.85%, PPV of 88.37%, and NPV of 99.61% in retrospective dataset. For 27 prospective patients, the model achieved a comparable performance to that of an expert radiologist with much shorter reading time (41.34s [IQR 39.76-44.48] vs. 115.50s [IQR 85.69-118.17] per patient).

A manuscript by Xu (on ArXiv: https://arxiv.org/abs/2002.09334) confirmed previous publications suggesting that artificial intelligence deep learning applied to the analysis of CT scans might be the basis of a novel diagnostic approach for COVID-19. The models developed in this study were reported to yield an overall diagnostic accuracy of 86.7 %.

Combination of chest CT and RT-PCR

A publication in Lancet (Shi Lancet Inf Dis 2020, see ***below***), which presents clinical imaging data from a large cohort of 81 patients, also states that combining imaging assessments with clinical and laboratory findings could help identify SARS-CoV-2 infections early. A similar conclusion was reached by Ren (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.25.20027755v2) based on 87 confirmed COVID-19 cases and 481 exclusion cases. Combination of RT-PCR and CT had higher sensitivity (91.9%) than RT-PCR alone (78.2%) or CT alone (66.7%) or combination of two RT-PCR tests (86.2%).

Virus isolation

The first SARS-CoV-2 was successfully isolated by inoculating human airway epithelial cells with bronchoalveolar-lavage fluid samples from a patient with pneumonia (Zhu NEJM 2020, see ***below***). Since human airway epithelial cells (because of their resemblance to pseudostratified mucociliary epithelium) require 4-6 weeks to differentiate *in vivo*, isolation of SARS-CoV-2 using Vero cells or Caco-II cells is more convenient. Kim (Osong Public Health Res Perspect 2020, see ***below***) showed virus replication in Vero cells, with cytopathic effects observed. The author indicated that further studies are needed to select more sensitive cell lines suitable for virus isolation from low viral load samples. Harcourt (Em Inf Dis 2020, see ***below***) presented data showing that the virus replicates to high titer in Vero-CCL81 cells and Vero E6 cells in the absence of trypsin.

Matsuyama (PNAS 2020, see ***below***) showed that a TMPRSS2-expressing Vero E6 cell line is highly susceptible to SARS-CoV-2 infection, making it useful for isolating and propagating the virus.

Alternative diagnostic methods

A manuscript by Wang (on ArXiv: https://arxiv.org/pdf/2002.05534.pdf) described the development of a technology for detection of abnormal respiratory patterns for large-scale screening of COVID-19 patients in an unobstructive manner.

Seo (ACS Nano 2020, see ***below***) reported a field-effect transistor (FET)-based biosensing device for detecting SARS-CoV-2 in clinical samples. This type of device has several advantages, including the ability to make highly sensitive and instantaneous measurements using small amounts of analytes. The sensor was produced by coating graphene sheets of FET with a specific antibody against SARS-CoV-2 spike protein. The performance of the sensor was determined using antigen protein, cultured virus, and nasopharyngeal swab specimens from COVID-19 patients. The FET device could detect SARS-CoV-2 S protein at concentrations of 1 fg/ml in PBS and 100 fg/ml clinical transport medium. In addition, the FET sensor successfully detected SARS-CoV-2 in culture medium (limit of detection [LOD]: 1.6 x 10^1 pfu/ml) and

clinical samples (LOD: 2.42 x 10^2 copies/ml). The device exhibited no measurable cross-reactivity with MERS-CoV antigen. Even though more validation data are needed, these results appear very promising.

Prevention and control strategies

Tanne (BMJ 2020, see ***below***) provided a rapid overview of how selected countries (US, Canada, Australia, India, Japan, South Korea, Italy, Spain, France, Germany, Iran) are tackling the epidemic in March 2020).

Disease surveillance guidelines

WHO issued guidance on implementation of global surveillance of COVID-19 by Member States (https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov), last updated on March 20). The objectives of this global surveillance are to monitor trends of the disease where human to human transmission occurs; rapidly detect new cases in countries where the virus is not circulating; provide epidemiological information to conduct risk assessments at the national, regional and global level; and provide epidemiological information to guide preparedness and response measures.

Recommendations for laboratory testing

Any persons meeting the criteria for testing should be tested for COVID-19 infection. Depending on the intensity of transmission, the number of cases and laboratory testing and surge capacity, it may be necessary to prioritize who gets tested. A WHO guidance (last updated on March 21st) is available to help define such priorities (https://apps.who.int/iris/bitstream/handle/10665/331509/WHO-COVID-19-lab_testing-2020.1-eng.pdf). The document focusses solely on molecular testing as this is the current recommended method for the identification of infectious cases.

Recommendations for reporting surveillance data to WHO

WHO requests that national authorities report probable and confirmed cases of novel coronavirus infection within 24 hours of identification, by providing the minimum data set outlined in the "Interim case reporting form for 2019 Novel Coronavirus of confirmed and probable cases". For countries with extensive importation or human-to-human transmission, daily aggregated data are requested, with reporting of the number of new confirmed and probable cases and deaths by first administrative level (e.g. region, province, state, municipalities) if possible.

Of note, in a press conference on Feb 4, WHO mentioned they only received complete information about 38% of the cases reported outside of China (https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-technical-briefing-on-2019-novel-coronavirus).

Public health response in China

As of 26 January 2020, in China, 30 provinces initiated a level-1 public health response to control COVID-19. As described by Deng (J ClinMed 2020, see ***below***), level-1 response means that during the occurrence of a particularly serious public health emergency, the provincial headquarters shall organize and coordinate the emergency response work within its administrative area according to the decision deployment and unified command of the State Council. Fever observation rooms were to be set up at stations, airports, ports, and so on to detect the body temperature of passengers entering and leaving the area and implement observation/registration for the suspicious patients. The government under its jurisdiction, in accordance with the law, is to take compulsory measures to restrict all kinds of the congregation, and ensure the supply of living resources. They also ensure the sufficient supply of masks, disinfectants, and other protective articles on the market, and standardize the market order. The strengthening of public health surveillance, hygiene knowledge publicity, and monitoring of public places and key groups is required. Comprehensive medical institutions and some specialized hospitals are to be prepared to accept COVID-19 patients to ensure that severe and critical cases can be differentiated, diagnosed, and effectively treated in time. The health administration departments, public health departments, and medical institutions at all (province, city, county, district,

township, and street) levels, and social organizations function in epidemic prevention and control and provide guidance for patients and close contact families for disease prevention.

Chen, Yang et al. (Lancet 2020, see ***below***) also underlined the importance of the social distancing measures that were applied during the Chinese Lunar New Year holiday in China. People in China are indeed estimated to make close to 3 billion trips over the 40-day travel period, or Chunyun, of the Lunar New Year holiday. As part of these social distancing policies, the Chinese Government encouraged people to stay at home; discouraged mass gatherings; cancelled or postponed large public events; and closed schools, universities, government offices, libraries, museums, and factories. Only limited segments of urban public transport systems remained operational and all cross-province bus routes were taken out of service. As a result of these policies and public information and education campaigns, Chinese citizens started to take measures to protect themselves against COVID-19, such as staying at home as far as possible, limiting social contacts, and wearing protective masks when they needed to move in public. The Chinese Government even extended the Lunar New Year holiday, so that the duration of the holiday would be sufficiently long to fully cover the suspected incubation period of COVID-19.

Public health response in other countries

On January 13 2020 the first case was reported outside China: a patient in Thailand reported to have visited the Huanan Seafood Wholesale Market (Bruinen de Bruin Saf Sci 2020, see ***below***). Due to the absence of a cure or a vaccine, controlling the infection to prevent the spread of COVID-19 was correctly seen as the only intervention that could be used. Risk mitigation measures were soon implemented on other areas and countries such as Hong Kong, Taiwan, South Korea and Mongolia. One of them consisted of contact tracing and recommending a set of precautions. In the United States, on January 20, state and local health departments, in collaboration with teams deployed from CDC, began identifying and monitoring all persons considered to have had close contact with patients with confirmed COVID-19 (Burke MMWR Morb Mortal Wkly Rep 2020, see ***below***). The aims of these efforts were to ensure rapid evaluation and care of patients, limit further transmission, and better understand risk factors for transmission.

Legido-Quigley (Lancet 2020, see ***below***) analysed the response in Hong Kong, Singapore and Japan. The three locations introduced appropriate containment measures and governance structures; took steps to support health-care delivery and financing; and developed and implemented plans and management structures. However, their response is vulnerable to shortcomings in the coordination of services; access to adequate medical supplies and equipment; adequacy of risk communication; and public trust in government. Moreover, it is uncertain whether these systems will continue to function if the requirement for services surges. Three important lessons have emerged. The first is that integration of services in the health system and across other sectors amplifies the ability to absorb and adapt to shock. The second is that the spread of fake news and misinformation constitutes a major unresolved challenge. Finally, the trust of patients, health-care professionals, and society as a whole in government is of paramount importance for meeting health crises.

The response of Singapore to contain the epidemic was also described in a publication by Lee (J Trav Med 2020, see ***below***).

From January 30, the Italian Government implemented extraordinary measures to restrict viral spread, including interruptions of air traffic from China, organised repatriation flights and quarantines for Italian travellers in China, and strict controls at international airports' arrival terminals (Spina Lancet 2020, see ***below***). Local medical authorities adopted specific WHO recommendations to identify and isolate suspected cases of COVID-19. Such recommendations were addressed to patients presenting with respiratory symptoms and who had travelled to an endemic area in the previous 14 days or who had worked in the health-care sector, having been in close contact with patients with severe respiratory disease with unknown aetiology. Suspected cases were transferred to preselected hospital facilities where the SARS-CoV-2 test was available and infectious disease units were ready for isolation of confirmed cases. Since the first case of SARS-CoV-2 local transmission was confirmed, the EMS in the Lombardy region (reached by dialling 112,

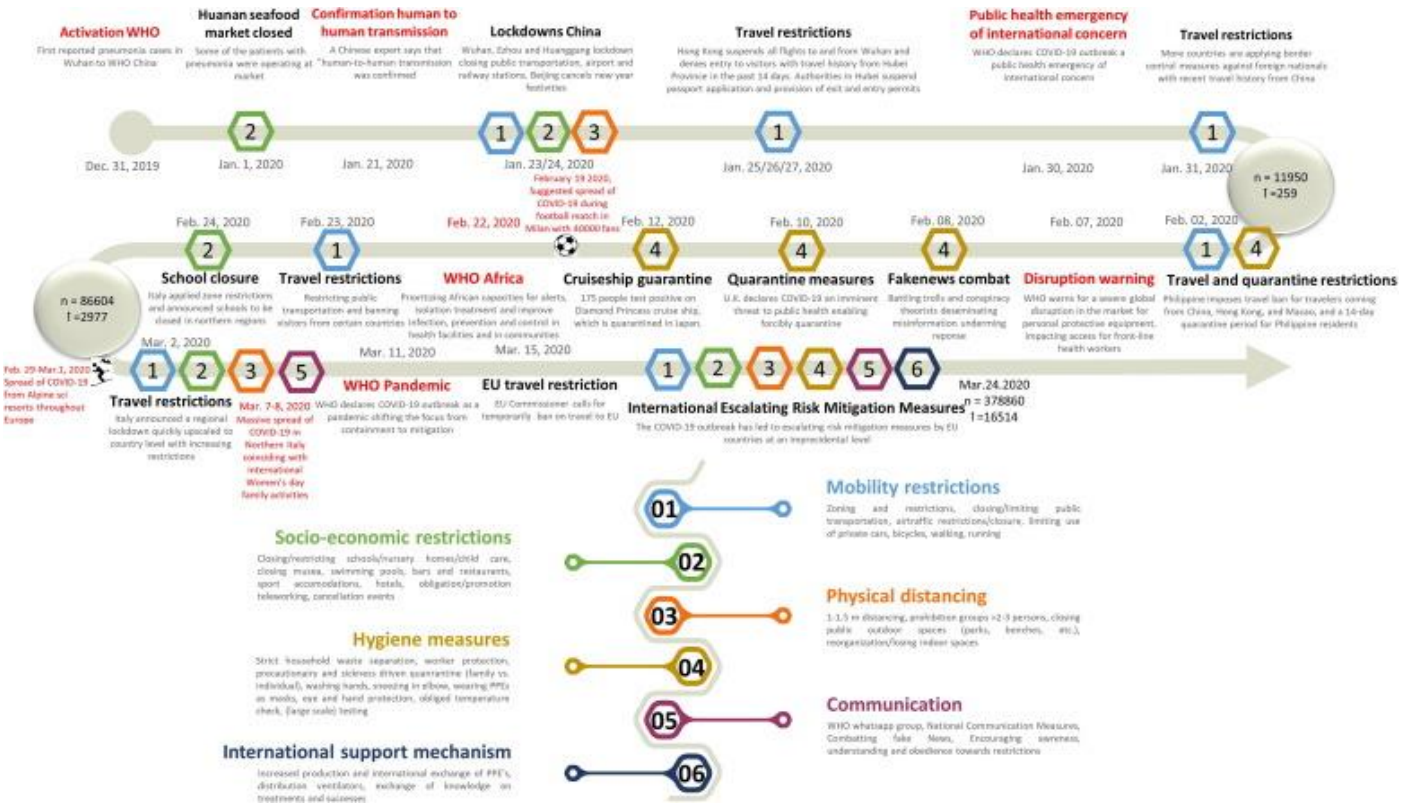
the European emergency number) represented the first response to handling suspected symptomatic patients, to adopting containment measures, and to addressing population concerns. The EMS of the metropolitan area of Milan instituted a COVID-19 Response Team of dedicated and highly qualified personnel, with the ultimate goal of tackling the viral outbreak without burdening ordinary EMS activity. More details on the consequences of the COVID-19 outbreak on critical care capacity were provided by Grasselli (JAMA 2020, see ***below***).

Johnson (Euro Surv 2020, https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.9.2000202) characterised three sequential scenarios for the spread of SARS-CoV-2 in the EU/EEA, with the third scenario divided in two sub-scenarios based on impact on the healthcare system (Figure 15). The scenarios are: (1) short, sporadic chains of transmission, (2) localised sustained transmission, (3a) widespread sustained transmission with increasing pressure on the healthcare system and (3b) widespread sustained transmission with overburdened healthcare system. These scenarios were presented together with suggested control measures to limit the impact of the epidemic. At different points in time, it was expected that different countries may find themselves in different scenarios.

In Japan, Machida (Int J Infect Dis 2020, see ***below***) evaluated the level of adoption of personal protective measures by citizens. The prevalence of the five personal protective measures (hand hygiene, social distancing measures, avoiding touching the eyes, nose and mouth, respiratory etiquette, and self-isolation) ranged from 59.8% to 83.8%, with the lowest being avoiding touching the eyes, nose, and mouth. In total, 34.7% implemented all personal protective measures. The median daily hand hygiene events were 5 per day (25th percentile, 75th percentile: 3,8). The authors concluded in an insufficient implementation of the protective measure.

Bruinen de Bruin (Saf Sci 2020, see ***below***) collated and clustered (using harmonised terminology) the risk mitigation measures taken around the globe in the combat to contain, and since March 11 2020, to limit the spread of the SARS-CoV-2 virus. Figure 15 describes the timeline of events up to end of March 2020.Figure 1

Figure 15 Time line of events and application of COVID-19 risk mitigation measures (from Bruinen de Bruin Saf Sci. 2020)



Of note, a convenient platform has been created for access to detailed information on how different countries respond to the pandemic (see: https://www.covid19healthsystem.org/mainpage.aspx).

Screening approaches

Thailand has 58 international flights connecting with Wuhan (Sriwijitalai Int J Prev Med 2020, see ***below***). Active screening at the airport (by body temperature scanning and clinical history taking) has been done to identify possible infected cases. In the first month of the epidemic, active screening identified 12 cases with positive result. However, the final diagnosis by molecular diagnostic tests could identify only one case with SARS-CoV-2 infection, which was the first case report of infection outside China. The other 11 cases were infected with influenza virus.

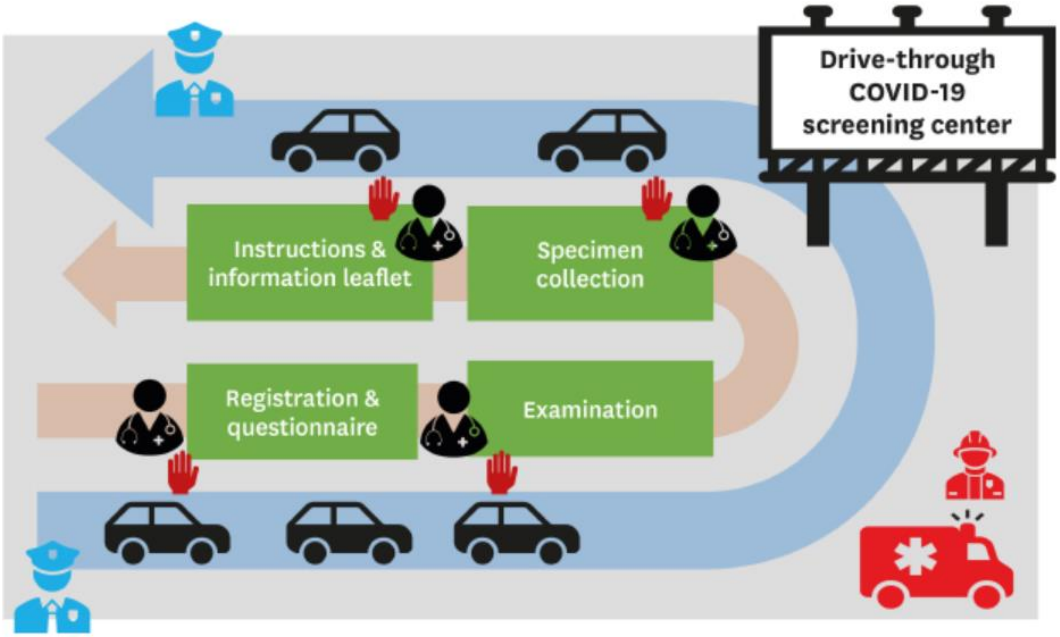
As reported by Ge (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.02.20.20025973v1), symptom-based mass screening and testing intervention (MSTI) can identify a large fraction of infected individuals during an infectious disease outbreak. China is currently using this strategy for the COVID-19 outbreak. The authors noted that this might lead to increased transmission if not properly implemented. The outcome of a modelling study suggested that the approach can be useful if the probability of transmission at testing sites is less than the probability that a symptomatic person is infected with SARS-CoV-2. This type of data is important to generate, as it may support recommendations such as for instance the use of dedicated testing sites separate from the usual healthcare facilities.

Gostic (Elife 2020, see ***below***) estimated the impact of different screening programs given current knowledge of key COVID-19 life history and epidemiological parameters. Even under best-case assumptions, the authors predicted that screening will miss more than half of infected people. Most cases missed by screening are fundamentally undetectable, because they have not yet developed symptoms and are unaware that they were exposed.

Rao (Infect Control Hosp Epidemiol 2020, see ***below***) proposed to use machine learning algorithms to help improve possible COVID-19 case identifications using a mobile phone-based web survey capturing with the most common manifestations of disease, along with basic travel history.

For safe and efficient screening for COVID-19, drive-through screening centres have been designed and implemented in South Korea. Kwon (J Korean Med Sci 2020, see ***below***) presented the overall concept, advantages, and limitations of these screening centres. The steps of the drive-through centres include registration, examination, specimen collection, and instructions (Figure 16). The entire service takes about 10 minutes for one testee without leaving his or her cars. Increased testing capacity over 100 tests per day and prevention of cross-infection between testees in the waiting space are the major advantages, while protection of staff from the outdoor atmosphere is challenging.

Figure 16 Illustration of drive-through COVID-19 screening centre provided for the public in South Korea (from Kwon J Korean Med Sci 2020)



Choi (Clin Exp Emerg Med 2020, see ***below***), and compared the advantages and disadvantages of Drive-Through and Walk-Through methods of testing. The same approach has been reported in Israel (Kim Disaster Med Public Health Prep 2020, see ***below***).

Contact tracing

A WHO document offers operational guidance to Member States for the rapid investigation of suspected COVID-19 cases (https://www.who.int/publications-detail/considerations-in-the-investigation-of-cases-and-clusters-of-covid-19). This guidance may be implemented in different countries with varying resources and epidemiological patterns and it is expected to be adapted accordingly.

When several unknown epidemiological and clinical characteristics of the disease remain and an effective medical intervention is lacking (as in the case of COVID-19), contact management becomes one of the core strategies to minimize additional transmission. Among the first 10 patients with travel-related confirmed COVID-19 reported in the United States, a total of 445 persons (range = 1-201 persons per case) who had close contact with one of the 10 patients on or after the date of the patient's symptom onset were identified (Burke MMWR Morb Mortal Wkly Rep 2020, see ***below***). 222 (50%) were health care personnel. Active symptom monitoring of the 445 close contacts, consisting of daily telephone, text, or in-person inquiries about fever or other symptoms for 14 days following the last known exposure to a person with confirmed COVID-19, was conducted by local health jurisdictions.

Traditional investigative methods, depending on the patient or proxy interview, has the limitation of omissions and errors associated with recalling previous activities (COVID-19 National Emergency Response Center Osong Public Health Res Perspect 2020, see ***below***). In South Korea for instance, the methods used to overcome recall and confirmation biases that can occur while determining the location of the contact include checking medical facilities records, phone-based global positioning system (GPS), card transaction records, and closed-circuit television (CCTV).

Pan (Irish J Med Sci 2020, see ***below***) also reported that several personal-oriented and mobile phone-based information technologies were developed and widely used in China. For instance, the application "Diagnosed Cases in Community" enables people to check the distribution of COVID-19 cases in local communities on the map. The map covers more than 130 cities in China and shows case number and location.

Kamel Boulos (Int J Health Geogr 2020, see ***below***) described a range of online/mobile geographic information systems (GIS) and applications for tracking the coronavirus epidemic and associated events as they unfold around the world. Some of these dashboards and applications are receiving data updates in near-real-time (at the time of writing).

However, as noted by Buckee (Science 2020, see ***below***), the protection of personal privacy must be paramount. Consent-based data sharing models and data protection laws provide for the legal grounds to use personal data during emergencies. However, the use of individual data is not advocated by all experts.

Face masks

Liu (Influenza Other Respir Vir 2020, see ***below***) reported an interesting anecdote suggesting the efficacy of face masks to present transmission of SARS-CoV-2. The authors observed a typical case of cluster outbreak caused by public transportation exposure during the outbreak of COVID-19. One patient from Chongqing, China, didn't wear a face mask in the first vehicle, while he wore a face mask in the second vehicle he took. This male patient with COVID-19 found himself coughing. Unaware of the fact that he might have been infected with COVID-19 and in a hurry, he didn't manage to get a face mask before he took the coach bus from the city back to his county. Many passengers didn't wear face masks on the same coach bus. The duration of this bus was 2 hours and 10 minutes; there were 39 other passengers on the same coach bus. According to epidemiological survey, 5 other passengers on the same coach bus were infected. Upon arrival in the county, this male patient bought a face mask and took a minibus to his final destination wearing the mask. The duration of minibus was 50 minutes, there were 14 other passengers on the same

minibus. The Center for Disease Control and Prevention conducted an epidemiological investigation and close contact tracing management. The passengers on the minibus that were screened and treated as suspected cases. A 14-day medical observation period was conducted. During the observation period, passengers were taken temperature twice a day. All the passengers did not have fever, cough or other abnormal symptoms, two quantitative RT-PCR test results were negative. No passengers were infected in the same minibus.

An interesting overview on the topic of face masks use indicated that for infected individuals, facemasks are likely to be superior to active practices such as covering up the nose or mouth when sneezing or coughing (Chan Int J Epidemiol 2020, see ***below***). However, a small study in 4 patients by Bae (Ann Intern Med 2020, see ***below***) concluded that both surgical and cotton masks seem to be ineffective in preventing the dissemination of SARS-CoV-2 from the coughs of patients with COVID-19 to the environment and external mask surface.

Evidence is still lacking to show that face mask use can reduce COVID-19 transmission to uninfected individuals in the general population (Chan Int J Epidemiol 2020, see ***below***). The authors noted that ultimately, the critical public health question is whether the potential benefits of facemask use outweigh the cost to the society. The sudden surge of demand on facemasks in East Asia (together with reduced productivity in China and other factors) has contributed to a global shortage that in turn has disrupted supplies to health care providers worldwide.

As an attempt at solving the shortage of protective facemasks for healthcare professionals, Swennen (Int J Oral Maxillofac Surg 2020, see ***below***) presented a proof of concept and prototype demonstrating a reusable custom-made three-dimensionally (3D) printed face mask based on materials and techniques (3D imaging and 3D printing) with global availability. The individualized 3D protective face mask consists of two 3D-printed reusable polyamide composite components (a face mask and a filter membrane support) and two disposable components (a head fixation band and a filter membrane).

Containment measures

Severe containment measures in China

China has taken draconian measures to contain the outbreak, including the quarantine of at least 30 million residents of Wuhan and neighbouring cities (Kickbusch British Med J 2020, see ***below***). Countrywide interventions include delaying resumption of school after the spring festival holiday, encouraging citizens to work from home and stay at home, using personal protective equipment such as face masks, and cancelling all mass gatherings. Vehicular traffic in Wuhan was banned. Authorities closed public transit and cancelled outbound transportation (air, train, and long-haul buses). China also imposed a ban on overseas travel with tour groups and suspended sale of flight and hotel packages. Authorities cancelled Lunar New Year gatherings in Beijing as well as intraprovince bus service into the nation's capital. China's Finance Ministry announced ¥1 billion (U.S. $145 million) to fund the response as well as the rapid construction of 2 hospitals in Wuhan to treat those affected (Phelan JAMA 2020, see ***below***).

Most districts of Hangzhou announced in a statement that every community would be kept under closed management, and only one family member was allowed to leave his house and buy daily living supplies outdoors every two days (Diao Infect Control Hosp Epidemiol 2020, see ***below***). Furthermore, "non-contact delivery", a new delivery method, was adopted by many express delivery companies, which could reduce contagion risk. Fourth, in order to reduce the concentration of personnel to avoid the risk of cross-infection, online working and network teaching were encouraged for workers and students, respectively, which were supported by mobile technology companies. Fifth, to meet the need of resumption of production and curb the transmission of the virus as far as possible, Hangzhou arranged chartered transportation to help numbers of migrants return to workplaces. Lastly, in cooperation with Alipay, Hangzhou adopted the health QR code system on February 11, 2020, which were designated by green, yellow or red. People who wanted to get into Hangzhou needed to submit their travel history and health information online in advance. Residents with a green code indicated they had a low current risk of being infected, while residents with

yellow or red codes were quarantined for seven or fourteen days and required to report their health condition every day to exclude infection before the codes turned green.

Initial measures in other countries

The Hong Kong Special Administrative Region declared its highest-tier emergency, curtailed public events, and barred travellers from Hubei Province. Travelers from mainland China had to complete health declarations. Hong Kong has also rapidly closed schools and universities.

Governments have not banned travel from China, with 2 exceptions: North Korea prohibited entry of all Chinese travellers and Kyrgyzstan closed its border with China. Multiple countries (e.g., Australia, Thailand, South Korea, Japan, India, Italy, Singapore, Malaysia, and Nigeria) have commenced temperature screening, symptom screening, and/or questionnaires for arriving passengers from China. The U.S. Centers for Disease Control and Prevention launched enhanced, non-invasive screening of travellers from Wuhan at 20 major airports, while the U.S. State Department issued its highest-level travel advisory for Hubei Province: level 4, "do not travel."

Efficacy of containment measures

A manuscript by Tian (on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.01.30.20019844v3) provides a preliminary evaluation of the efficacy of control measures implemented in China. The Wuhan city travel ban is considered to have slowed the dispersal of infection to other cities by an estimated 2.91 days (95% CI, 2.54-3.29) on average. Among the other urban centres across mainland China, cities that implemented control measures pre-emptively, before the first case was reported, had 37% fewer cases in the week following the first reported case (13.0, 95%CI 7.1-18.8) compared with cities starting control after the first case (20.6, 95%CI 14.5-26.8). Among individual control measures investigated, the most effective were suspending intra-city public transport, and closing entertainment venues and banning public gatherings.

A Cochrane rapid review assessed the effects of quarantine (alone or in combination with other measures) of individuals who had contact with confirmed cases of COVID-19, who travelled from countries with a declared outbreak, or who live in regions with high transmission of the disease (Nussbaumer-Streit Cochrane Database Syst Rev 2020, see ***below***). Evidence for COVID-19 is limited to modelling studies that make parameter assumptions based on the current, fragmented knowledge. Findings consistently indicated that quarantine is important in reducing incidence and mortality during the COVID-19 pandemic.

A role for telemedicine

Zhai (manuscript on MedRXiv : https://www.medrxiv.org/content/10.1101/2020.02.20.20025957v1) described the Emergency Telemedicine Consultation System (ETCS), a telemedicine-enabled outbreak alert and response network, established by the National Telemedicine Center of China in Zhengzhou. ETCS was built upon a doctor-to-doctor (D2D) approach, in which health services can be accessed remotely through terminals across hospitals. The system architecture of ETCS comprises three major architectural layers: (1) telemedicine service platform layer, (2) telemedicine cloud layer, and (3) telemedicine service application layer. The ETCS has demonstrated substantial benefits in terms of the effectiveness of consultations and remote patient monitoring, multidisciplinary care, and prevention education and training.

Hollander (NEJM 2020, see ***below***) presented the benefits that can be expected from telemedicine. Direct-to-consumer (or on-demand) telemedicine allows patients to be efficiently screened. It is both patient-centered and conducive to self-quarantine, and it protects patients, clinicians, and the community from exposure. It can allow physicians and patients to communicate 24/7, using smartphones or webcam-enabled computers. Health care providers can easily obtain detailed travel and exposure histories. Automated screening algorithms can be built into the intake process, and local epidemiologic information can be used to standardize screening and practice patterns across providers. Interestingly, more than 50 U.S. health systems already have such programs, and systems lacking

such programs can outsource similar services. However, the authors also identified the numerous challenges to be faced (incl. reimbursement) before such approach can be used in the management of COVID-19 in the U.S.

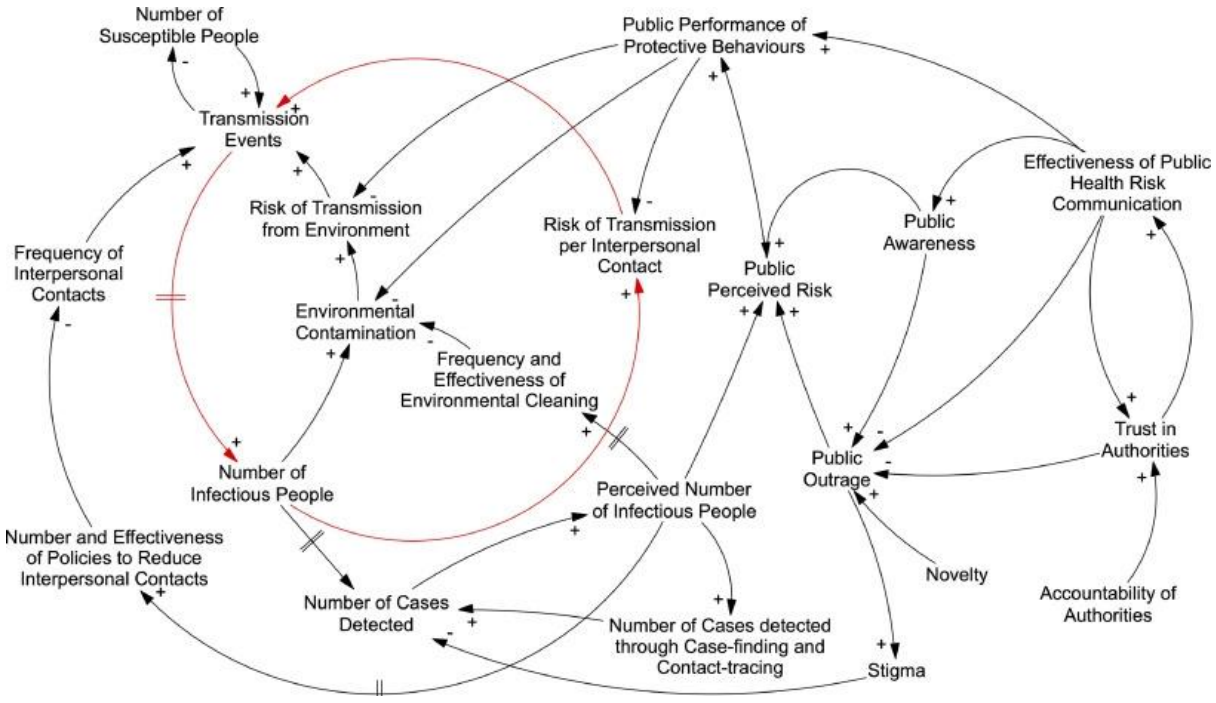
Greenhalgh (BMJ 2020, see ***below***) reported that video could be useful for people with heightened anxiety (for whom a video consultation may be more reassuring than a phone call), those with mild symptoms suggestive of coronavirus (for which visual cues may be useful), and those with more severe symptoms (when a video consultation may reduce the need to visit a potentially contagious patient). Well patients seeking general advice could be directed to a website or recorded phone message. Moreover, there may be a trade-off between staying at home and coming to clinic for a full examination—for example, in frail older patients or immunosuppressed patients.

A study by Khairat (JMIR Public Health Surveill 2020, see ***below***) assessed the potential of a system call Virtual Care. The study included 733 total virtual visits, including 257 (35%) with COVID-19-like symptoms. Of the COVID-19 like visits, the number of females was 178 (70%). People in the 30-39 years of age (26%) and 40-49 years (25%) were 50% of the total patients. Virtual Care was shown to provide efficient triaging. The authors concluded that Virtual Care is capable to reduce emergency room visits, conserve healthcare resources, and avoid the spread of COVID-19 by treating patient remotely.

Systems approaches

Bradley (EClinicalMedicine 2020, see ***below***) highlighted the importance of a systems approach to help policymakers understand and influence the spread of infection and its multifaceted consequences across the community. The author outlined a causal loop diagram to illustrate some important interacting components in a society that is responding to the threat of COVID-19 (Figure 17).

Figure 17 An example causal loop diagram illustrating some of the interacting components in a society responding to the threat of COVID-19 (from Bradley EClinicalMedicine 2020)



Infection control in health care settings

As reported by Wang (J Hosp Inf 2020, see ***below***), by 24th February, the National Health Commission of the People's Republic of China reported in a press conference of WHO-China Joint Mission on COVID-19 that 3 387 healthcare workers had been confirmed with COVID-19, with 22 (0.6%) deaths. More than 90% of infected HCWs were from Hubei

province. The director of National Hospital Infection Management and Quality Control Centre summarized some reasons for such high number of infected HCWs during emergency outbreak. These included inadequate personal protection of HCWs at the beginning of the epidemic; long-time exposure to large-scale of infected patients, which directly increased the risk of infection for HCWs; pressure of treatment, work intensity, and lacking of rest, which indirectly increased the probability of infection for HCWs; shortage of personal protective equipment (PPE) ; and inadequate training to infection prevention and control for front-line HCWs (except infectious disease physicians).

Guidance on infection prevention and control strategies for use when COVID-19 is suspected has been issued by WHO (https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125, last updated March 19). This guidance is intended for HCWs, healthcare managers and IPC teams at the facility level but it is also relevant for the national and district/provincial level. More detailed practical recommendations can also be found at : https://www.who.int/teams/risk-communication/health-sector.

Additional recommendations are available at country level, as done for instance in Canada (Wax Can J Anaesth 2020, see ***below***).

Personal protection of health-care workers

Available epidemiological data show that not only can subclinical patients transmit the virus effectively but patients can also shed high amounts of the virus and infect others even after recovery from the acute illness. Chang (Lancet Resp Med 2020, see ***below***) concluded that these findings warrant aggressive measures (such as N95 masks, goggles, and protective gowns) to ensure the safety of HCWs during the COVID-19 outbreak especially in the initial stages where limited information about the transmission and infective potency of the virus is available.

A manuscript by Wang on MedRxiv supports the efficacy of N95 respirators, disinfection and hand washing to reduce risk of COVID-19 transmission among medical staff at Zhongnan Hospital of Wuhan University (https://www.medrxiv.org/content/10.1101/2020.02.18.20021881v1).

A systematic review and meta-analysis of randomized trials by Bartoszko (Influenza Other Respir Viruses 2020, see ***below***) compared medical masks to N95 respirators in preventing laboratory confirmed viral infection and respiratory illness including coronavirus. Compared to N95 respirators; the use of medical masks did not increase laboratory confirmed viral (including coronaviruses) respiratory infection (OR 1.06; 95% CI 0.90-1.25; I2 =0%; low certainty in the evidence) or clinical respiratory illness (OR 1.49; 95%CI 0.98-2.28; I2 =78%; very low certainty in the evidence). Only one trial evaluated coronaviruses separately and found no difference between the two groups (p=0.49).

Of note, a medical expert, who visited Wuhan to investigate the COVID-19 outbreak, after returning to Beijing, initially exhibited conjunctivitis of the lower left eyelid before the appearance of catarrhal symptoms and fever. The individual tested positive for COVID-19, suggesting the virus tropism to non-respiratory mucosal surfaces, limiting the effectiveness of face masks (Chang Lancet Resp Med 2020, see ***below***).

Yan (Dermatol Ther 2020, see ***below***) presented a consensus of Chinese experts on protective measures and advice on hand-cleaning- and medical-glove-related hand protection, mask- and goggles-related face protection, UV-related protection, eye protection, nasal and oral mucosa protection, outer ear and hair protection. The authors noted that insufficient and excessive protection will have adverse effects on the skin and mucous membrane barrier and that using moisturizing products is highly recommended to achieve better protection.

Zhao (J Cardiothorac Vasc Anesth 2020, see ***below***) described more specifically the level 3 personal protective measures for healthcare workers to be used for emergency procedures in patients with confirmed or suspected SARS-CoV-2 infection in China. They included hand disinfection, wearing a cap, a medical protective mask, goggles/face screens/eye protective surgical masks, isolation gowns/protective suits, shoe-covers and gloves.

A review by Cook (Anaesthesia 2020, see ***below***) indicated that personal protective equipment is an important component, but only one part, of a system protecting staff and other patients from COVID-19 cross-infection. Appropriate use significantly reduces risk of viral transmission. Personal protective equipment should logically be matched to the potential mode of viral transmission occurring during patient care - contact, droplet, or airborne. Recommendations from international organisations are broadly consistent, but equipment use is not. Only airborne precautions include a fitted high-filtration mask, and this should be reserved for aerosol-generating procedures. Uncertainty remains around certain details of personal protective equipment including use of hoods, mask type and the potential for re-use of equipment.

Due to the risk of hand-skin damage, it has also been recommended that HCWs are instructed about rational hand-hygiene measures respectful of the skin along with proper use of protective gloves and moisturizers (Cavanagh J Am Acad Dermatol 2020, see ***below***).

Facilities

As of February 19th, the Chinese government converted 13 large-scale public places in Wuhan into makeshift hospitals for patients with COVID-19 with mild symptoms. Chen (J Hosp Inf 2020, see ***below***) noted that insufficient ventilation in these makeshift hospitals may increase infection risk of opportunistic airborne transmission.

Patient flow and triage

An innovative approach was developed in the United Kingdom to stop unnecessary ambulance use and hospital visits, whereby people with suspected COVID-19 are being tested in their homes (Mahase BMJ 2020, see ***below***). The community testing scheme started at the end of January at North West London NHS Trust and has now been implemented in other trusts. More than 130 patients have been reported to be tested in two weeks. Mahase (BMJ 2020, see ***below***) subsequently indicated that in Wales, 90% of suspected cases are managed at home. Members of the public who call NHS or 111 and are assessed as a possible case, are evaluated for their suitability for home testing on the basis of their self-reported health status and their ability to self-isolate at home. Public Health Wales's microbiology team then coordinates with the relevant health board community testing teams to arrange home testing within 12-36 hours.

Safety of procedures

Wong (Can J Anaesth 2020, see ***below***) described the outbreak response measures of the anaesthetic department of 2 hospitals in Singapore. These included engineering controls such as identification and preparation of an isolation operating room, administrative measures such as modification of workflow and processes, introduction of personal protective equipment for staff, and formulation of clinical guidelines for anaesthetic management.

Aerosol-generating procedures, such as non-invasive ventilation (NIV), high-flow nasal cannula (HFNC), bag-mask ventilation, and intubation are of particularly high risk when dealing with COVID-19 patients. Cheung (Lancet Respir Med 2020, see ***below***) described the approach developed by a local intensive care unit in a Hong Kong hospital to managing the risks to health-care staff, while maintaining optimal and high-quality care. They do not recommend using NIV or HFNC until the patient is cleared of COVID-19. Airway devices providing 6 L/min or more of oxygen are considered high-flow and they discourage their use if an airborne infection isolation room is unavailable. They recommend that endotracheal intubation is done by an expert specialised in the procedure, and early intubation considered in a patient with deteriorating respiratory condition. They recommend avoiding bag mask ventilation for as long as possible; and optimising preoxygenation with non-aerosol-generating means. Methods include the bed-up-head-elevated position, airway manoeuvres, use of a positive end expiratory pressure valve, and airway adjuncts.

Zuo (Chin Med Sci J. 2020, see ***below***) noted that endotracheal intubation may put the anaesthesiologists at high risk of nosocomial infection. In fact, SARS-CoV-2 infection of anaesthesiologists after endotracheal intubation for confirmed COVID-19 patients have been reported in hospitals in Wuhan. The expert panel of airway management in

Chinese Society of Anaesthesiology drafted a recommendation to guide the performance of endotracheal intubation by frontline anaesthesiologists and critical care physicians.

Zhang (Anesthesiology 2020, see ***below***) also reported that the Wuhan Union Hospital's Department of Anaesthesiology drafted the "Perioperative Care Provider's Considerations in Managing Patients with COVID-19" and carried out 45 surgical procedures on such patients. An upgraded surgical safety checklist for patients with suspected or confirmed COVID-19 was drawn up and implemented, along with infection-control guidelines for the care of such patients. Task forces dedicated to procedure standardization, infection control, and staff scheduling within anaesthesia were quickly assembled in most hospitals across the country. Monitoring was implemented to ensure that anaesthesia providers wore and removed personal protective equipment before working in the perioperative environment. Drills were held to ensure the optimal management of emergencies, with mandatory multidisciplinary participation across anaesthesia, surgery, critical care, paediatrics, and obstetrics and gynaecology.

Of note, another report noted that during pandemics the number of intensive care unit beds for mechanical ventilation through tracheal intubation could rapidly become insufficient. Therefore, non-invasive ventilation could be required outside the intensive care unit. To increase safety during NIV, use of a helmet has been suggested by Cabrini (Lancet 2020, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30359-7/fulltext).

In order to limit the risk of nosocomial transmission, Chen, Tian et al. (Lancet Inf Dis 2020, see ***below***) reported the use of an innovative infection-control system in a Guangdong hospital, called the "observing system", whereby cameras cover the negative pressure isolation ward and infection control observers monitor medical staff and provide assistance in real time via computer monitors. The main responsibilities of these infection control observers are to maintain the normal operation of the negative pressure isolation wards, supervise the implementation of disinfection, ensure a sufficient supply of protective materials, arrange specimens for inspection, and relieve anxiety of the medical personnel while treating patients.

Guidelines

A rapid advice guideline suitabl for the first frontline doctors and nurses, managers of hospitals and healthcare sections, as well as community residents or public health persons has been made available by Jin (Mil Med Res 2020, see ***below***). This guideline covers disease screening and population prevention, diagnosis, treatment and control (including traditional Chinese Medicine), nosocomial infection prevention and control, and disease nursing of the 2019-nCoV.

Availability of medical supplies

A comment by Wang (Biosci Trends 2020, see ***below***) addressed the importance of medical supplies availability. As the pandemic developed in China, a serious dearth of emergency medical supplies emerged, and especially an extreme shortage of personal protective equipment such as masks and medical protective clothing. This is considered as one of the major factors affecting the progress of epidemic prevention and control.

Modelling studies

A huge number of modelling studies related to COVID-19 has been reported. These studies aimed at characterizing the epidemiology of the disease in various countries, but also predicting the impact of various public health measures. The publications can be found at https://github.com/midas-network/COVID-19/wiki/Documents#estimate. The examples presented below are classified according to the objectives of the study.

Modelling key characteristics of the epidemic

- Pan (on MedRxiv https://www.medrxiv.org/content/10.1101/2020.02.19.20025387v3) described 2 mathematical models simulating the epidemic in Wuhan and other parts of China, taking into account the mobility of people. The data suggest that the peak of new asymptomatic cases per day in Wuhan occurred on

February 6, and the peak of new symptomatic infections on February 3. The model predicts that COVID-19 cases will gradually wane by the end of April 2020, both in Wuhan and the other parts of China.

- Based on the 199 first confirmed cases on the Diamond Princess cruise ship, Nishiura (J Clin Med 2020, see ***below***) employed a back-calculation method to estimate the incidence of infection. Without the movement restriction policy imposed from 5 February, it was predicted that the cumulative incidence with and without close contact would have been as large as 1373 (95% CI: 570, 2176) and 766 (95% CI: 587, 946) cases, respectively, out of a total of 3711 persons (2666 passengers and 1045 crew members).
- Thompson (J Clin Med 2020, see ***below***) estimated the probability that an imported case is followed by sustained human-to-human transmission to 0.41 (credible interval [0.27, 0.55]).
- Tuite (Lancet Inf Dis 2020, see ***below***) suggested that the numerous COVID-19 case exportations from Italy early March indicated an epidemic that was larger than official case counts suggested. The authors estimated non-identification of cases to reach 72% (61–79%) of cases, corresponding to a true outbreak size of 3971 cases (95% CI 2907–5297) vs. a reported case count of 1128 on Feb 29, 2020.
- De Salazar (Em Inf Dis 2020: https://wwwnc.cdc.gov/eid/article/26/7/20-0250_article) used air travel volume estimates from Wuhan, China, to international destinations and a generalized linear regression model to identify locations that could have undetected imported cases. The data led to a recommendation of rapid strengthening of surveillance and control efforts in locations like Indonesia. By contrast, India and Singapore were found to have more cases reported than expected from the model.
- Li (Science 2020, see ***below***) used observations of reported infections within China, in conjunction with mobility data, a networked dynamic metapopulation model and Bayesian inference, to infer critical epidemiological characteristics associated with SARS-CoV2, including the fraction of undocumented infections and their contagiousness. The authors estimated 86% of all infections were undocumented (95% CI: 82%–90%) prior to 23 January 2020 travel restrictions. Per person, the transmission rate of undocumented infections was 55% of documented infections (46%–62%), yet, due to their greater numbers, undocumented infections were the infection source for 79% of documented cases. These findings help explain the rapid geographic spread of SARS-CoV-2 and indicate containment of this virus is particularly challenging.
- Rocklöv (J Travel Med 2020, see ***below***) noted that empirical observations suggesting population density can have large impacts on R0 through the contact rates. On the Diamond Princess cruise ship, both the population density and R0 was estimated approximately four times greater than that in Wuhan. Therefore, the authors recommend avoiding situations with higher population densities to limit the spread of COVID-19.
- Kissler (Science 2020,https://science.sciencemag.org/content/early/2020/04/14/science.abb5793?rss=1) used estimates of βCoVs OC43 and HKU1 to inform a model of SARS-CoV-2 transmission. The authors projected that recurrent wintertime outbreaks of SARS-CoV-2 will probably occur after the initial, most severe pandemic wave. They suggested that, to avoid exceeding critical care capacities, prolonged or intermittent social distancing may be necessary into 2022. Moreover, they predicted that even in the event of apparent elimination, a resurgence in contagion could be possible as late as 2024.
- Debora MacKenzie (New Scientist 2020, see ***below***) referred to modelling data suggesting that only 10 per cent of cases are responsible for 80 per cent of transmission.
- Kim (Epidemiol Health 2020, see ***below***) modelled the COVID-19 outbreak in the Republic of Korea by applying a mathematical model of transmission that factors in behavioural changes. The model demonstrated that the relatively high per-capita rate of transmission and the low rate of changes in behaviour have caused a large-scale transmission of COVID-19 in the Daegu/Gyeongbuk area in the Republic of Korea.

Modelling the impact of public health measures

- Gostic estimated the effectiveness of symptom and risk screening to prevent the spread of COVID-19 (Elife. 2020, see ***below***)

- Anzai assessed the impact of reduced travel on exportation dynamics of COVID-19 (J Clin Med 2020, see ***below***)
- Hellewell (Lancet Glob Health 2020, see ***below***) used a mathematical model to assess if isolation and contact tracing are able to control onwards transmission from imported cases of COVID-19. The authors found that the probability of controlling an outbreak decreased with the number of initial cases, when R0 was 2·5 or 3·5 and with more transmission before symptom onset. Across different initial numbers of cases, the majority of scenarios with an R0 of 1·5 were controllable with less than 50% of contacts successfully traced. To control the majority of outbreaks, for R0 of 2·5 more than 70% of contacts had to be traced, and for an R0 of 3·5 more than 90% of contacts had to be traced. The delay between symptom onset and isolation had the largest role in determining whether an outbreak was controllable when R0 was 1·5. For R0 values of 2·5 or 3·5, if there were 40 initial cases, contact tracing and isolation were only potentially feasible when less than 1% of transmission occurred before symptom onset.
- Chinazzi (Science 2020, see ***below***) used a global metapopulation disease transmission model to project the impact of travel limitations on the national and international spread of the epidemic. The model was calibrated based on internationally reported cases, and shows that at the start of the travel ban from Wuhan on 23 January 2020, most Chinese cities had already received many infected travellers. The travel quarantine of Wuhan delayed the overall epidemic progression by only 3 to 5 days in Mainland China, but had a more marked effect at the international scale, where case importations were reduced by nearly 80% until mid-February. Modelling results also suggested that sustained 90% travel restrictions to and from Mainland China only modestly affected the epidemic trajectory unless combined with a 50% or higher reduction of transmission in the community.
- Wells (PNAS 2020, see ***below***) estimated the impact of these control measures and investigated the role of the airport travel network on the global spread of the COVID-19 outbreak. Our results show that the daily risk of exporting at least a single SARS CoV-2 case from mainland China via international travel exceeded 95% on January 13, 2020. The authors found that 779 cases (95% CI: 632 to 967) would have been exported by February 15, 2020 without any border or travel restrictions and that the travel lockdowns enforced by the Chinese government averted 70.5% (95% CI: 68.8 to 72.0%) of these cases. In addition, during the first three and a half weeks of implementation, the travel restrictions decreased the daily rate of exportation by 81.3% (95% CI: 80.5 to 82.1%), on average.
- Lau (J Trav Med 2020, see ***below***) evaluated whether rigorous lockdown measures as implemented by China have the potential to slow down the virus' spread. The authors reported a significant decrease in the growth rate of the epidemic. Moreover, a corresponding increase in the doubling time of COVID-19 cases within China was observed, from 2 days (95% Confidence Interval, CI): 1.9-2.6), to 4 days (95% CI: 3.5-4.3) after lockdown. However, the authors also noted that the number of cases outside lockdown areas have increased, and new epicenters are developing across the globe.
- Wang (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.03.03.20030593v1) divided the epidemic in China into four periods based on key events and interventions, compared epidemiological characteristics across periods and demographic groups, and developed a susceptible-exposed-infectious-recovered model to evaluate the impact of interventions. The authors found that the effective reproductive number dropped from 3.86 (95% credible interval 3.74 to 3.97) before interventions to 0.32 (0.28 to 0.37) post interventions. The interventions were estimated to prevent 94.5% (93.7 to 95.2%) infections till February 18. They noted that at least 59% of infected cases were unascertained in Wuhan, potentially including asymptomatic and mild-symptomatic cases.
- Liu (Biology 2020, see ***below***) developed another mathematical model for the disease, which predictions emphasize the importance of major public health interventions such as isolation, quarantine, and public closings, to greatly reduce the final size of this epidemic, and make the turning point much earlier than without these measures.

- Karako (Biosci Trends 2020, see ***below***) presented a stochastic transmission model by extending the Susceptible-Infected-Removed (SIR) epidemiological model with an additional modelling of the individual action on whether to stay away from the crowded areas. The authors concluded that the infection spread in Japan would be gradually contained by reducing the time spent in the crowded zone to less than 4 hours.
- Kraemer (Science 2020: https://science.sciencemag.org/content/early/2020/03/25/science.abb4218) used real-time mobility data from Wuhan and detailed case data including travel history to elucidate the role of case importation on transmission in cities across China and ascertain the impact of control measures. The authors showed that travel restrictions are particularly useful in the early stage of an outbreak when it is confined to a certain area that acts as a major source. However, travel restrictions may be less effective once the outbreak is more widespread.
- Rong (Math Biosci Eng 2020, see ***below***) investigated the effect of delay in diagnosis on disease transmission with a new formulated dynamic model, and showed that improving the proportion of timely diagnosis and shortening the waiting time for diagnosis cannot eliminate COVID-19, but can effectively decrease the basic reproduction number and significantly reduce the transmission risk.
- Ferretti (Science 2020, see ***below***) determined requirements for case isolation and contact-tracing to stop the epidemic. The authors concluded that viral spread is too fast to be contained by manual contact tracing, but could be controlled if this process was faster, more efficient and happened at scale. A contact-tracing App which builds a memory of proximity contacts and immediately notifies contacts of positive cases can achieve epidemic control if used by enough people. The model concluded that such mobile phone App could reduce transmission enough to achieve $R < 1$ and sustained epidemic suppression, stopping the virus from spreading further. A web interface has been made available online to explore the uncertainty in the modelling assumptions (https://bdi-pathogens.shinyapps.io/covid-19-transmission-routes/).
- Sjödin (Euro Surveill 2020, see ***below***) investigated the extent of physical distancing needed to effectively control the outbreak in a lockdown situation in a small size town setting typical of Italy. The authors showed that very high adherence to community quarantine (total stay-home policy) and a small household size is necessary for curbing the outbreak in a locked-down town. The larger the household size and amount of time in the public, the longer the lockdown period needed.

In addition, a publication by Roy Anderson (Lancet 2020, see ***below***) discussed the various unknowns that remain with regard to the epidemiology of the disease and the expected impact of various public health strategies. It provides a useful overview of the topic.

Roda (Inf Dis Modelling 2020, see ***below***) demonstrated that non-identifiability in model calibrations using the confirmed-case data is the main reason for the wide variations observed across prediction models for the COVID-19 epidemics in Wuhan and other parts of China. The authors suggested that predictions using more complex models may not be more reliable compared to using a simpler model.

Jewell (JAMA 2020, see ***below***) addressed the topic of epidemic modelling and accuracy of projections. It indicated for instance, that for large countries, such as the US, modelling is even more problematic because of heterogeneous subepidemics in local areas. Individual characteristics, such as age and comorbidities, influence risk of serious disease from COVID-19, but population distributions of these factors vary widely in the US.

Therapeutic interventions and research

Identifying treatment options as soon as possible is critical for the response to the COVID-19 outbreak (Lu Biosci Trends 2020, see ***below***). Various approaches, including evaluation of existing broad-spectrum antiviral drugs using standard assays, screening of a chemical library containing many existing compounds or databases, and the redevelopment of new specific drugs based on the genome and biophysical understanding of individual coronaviruses, can be used to

identify potential therapies. Numerous candidates were proposed from the beginning of the epidemic, some of which were very soon administered to patients.

A list of candidate therapeutics has been published by WHO (https://www.who.int/blueprint/priority-diseases/key-action/overview-ncov-therapeutics.pdf?ua=1). The Chinese Academy of Sciences also suggested a list of 30 different compounds, with 12 HIV medicines, including saquinavir, indinavir, lopinavir, ritonavir and carfilzomib, two respiratory syncytial virus drugs, a schizophrenia medication and an immunosuppressant. Candidates also include certain Traditional Chinese Medicines. The efficacy and safety of these candidates for COVID-19 still need to be confirmed by robust clinical evaluations.

Subsequent publications on this topic presented additional lists of potential compounds. For instance, Li provided a longer list of anti-coronavirus agents, including preclinical compounds that could be considered for screening or starting points for optimizing antiviral agents (https://www.nature.com/articles/d41573-020-00016-0).

A manuscript by Yan (https://www.preprints.org/manuscript/202002.0254/v1) also indicated that in addition to synthetic compounds (including FDA-approved drugs), Chinese Patent Drugs (CPD) can also be a source of therapies against COVID-19. He compiled major components from 38 CPDs that are commonly used in the respiratory diseases and docked them against two drug targets, ACE2 receptor and viral main protease. Ten antiviral components, including hesperidin, saikosaponin, rutin, baicalin, glycyrrhizin, mulberroside A, puerarin, orientin, amygdalin, and ilexgenin A, were predicted as able to directly bind to both host cell target ACE2 receptor and viral target main protease, indicating their potential for treatment.

In silico work is still ongoing to identify potential drug candidates. Using network proximity analyses of drug targets and known human CoV-host interactions in the human protein-protein interactome, Zhou (Cell Discov 2020, see ***below***) computationally identified 135 putative repurposable drugs for the potential prevention and treatment of human CoV infections. In addition, he prioritized 16 potential repurposable drugs (including melatonin, mercaptopurine, and sirolimus) that were further validated by enrichment analyses of drug-gene signatures and CoV-induced transcriptomics data in human cell lines. Finally, he presented three potential drug combinations (including sirolimus plus dactinomycin, mercaptopurine plus melatonin, and toremifene plus emodin) captured by the Complementary Exposure pattern: the targets of the drugs both hit the human CoV-host subnetwork, but target separate neighbourhoods in the human protein-protein interactome network.

As live SARS-CoV-2 handling requires high-level biosafety facilities, Fan (Chin Med J 2020, see ***below***) suggested the use of a pangolin coronavirus model to facilitate *in vitro* studies of potential drug candidates against COVID-19. The drug candidates were screened for their ability to inhibit cytopathic effect upon GX_P2V/pangolin/2017/ Guangxi strain infection of Vero E6 cells. The approach identified cepharanthine, selamectin and mefloquine hydrochloride as potential drugs.

Importantly, a publication in Nature (Maxmen 2020, see ***below***) reported the launch of more than 80 clinical trials to test candidate coronavirus treatments.

Management of early symptoms

The French minister, Oliver Veran, tweeted on March 14th that people with suspected COVID-19 should avoid anti-inflammatory drugs. “Taking anti-inflammatory drugs (**ibuprofen**, cortisone . . .) could be an aggravating factor for the infection. If you have a fever, take paracetamol,” he said. His comments seem to have stemmed in part from remarks attributed to an infectious diseases doctor in south west France (Day BMJ 2020, see ***below***). She was reported to have cited four cases of young patients with covid-19 and no underlying health problems who went on to develop serious symptoms after using non-steroidal anti-inflammatory drugs (NSAIDs) in the early stage of their symptoms. Some experts in the UK backed this sentiment that for treating symptoms such as fever and sore throat, it seems sensible to

stick to paracetamol as first choice. In parallel, the EMA stated that there is currently no scientific evidence establishing a link between ibuprofen and worsening of COVID-19 (https://www.ema.europa.eu/en/news/ema-gives-advice-use-non-steroidal-anti-inflammatories-covid-19). An overview by Sodhi (Chest 2020, see ***below***) confirmed that the current epidemiological evidence is not strong enough to infer a causal link of a harmful effect of ibuprofen in patients with COVID-19.

Antiviral drugs

Various antiviral drug candidates have been rapidly assessed in COVID-19 patients. While the outcome of controlled randomized trials is still expected, an analysis of the clinical characteristics, treatment and prognosis of 280 patients from four Chinese hospitals from January 20 to February 19, 2020 (who received antiviral treatment, including ribavirin, lopinavir or ritonavir) helped make useful observations (Wu J Intern Med 2020, see ***below***). A multivariate analysis revealed indeed that comorbidity, time from illness onset to antiviral treatment and age >=65 were found as independent risk factors for COVID-19 progression. Comorbidity and time from illness onset to antiviral treatment were both highly correlated with the average time of COVID-19 recovery ($r = 0.759$ and $r = 0.785$, both $P < 0.001$).

Inhibitors of virus entry

Chloroquine, hydroxychloroquine and analogues

Chloroquine and its structural analogues such as hydroxychloroquine, amodiaquine, pamaquine, plasmoquine, primaquine, mefloquine or ferroquine, have been used for decades as the primary and most successful drugs against malaria (Al-Bari 2017). These drugs are also found to be effective against a wide variety of viral infections. Chloroquine is known to block virus infection by increasing endosomal pH required for virus/cell fusion, as well as interfering with the glycosylation of cellular receptors of SARS-CoV (Wang Cell Res 2020, see ***below***). Besides its antiviral activity, chloroquine has an immune-modulating activity, which may synergistically enhance its antiviral effect *in vivo*. Chloroquine is widely distributed in the whole body, including lung, after oral administration. Devaux (Int J Antimicr Ag 2020, see ***below***) recently provided an overview of the possible mechanisms of chloroquine interference with SARS-CoV-2 replication.

Of note, several clinical studies of chloroquine and its analogues have been conducted for treatment of dengue, hepatitis C virus, chikungunya and HIV-1 infections. Disappointingly, the outcome of one of these clinical trials showed no benefit of chloroquine treatment of dengue virus infection (Tricou 2010). More recently, Garbern (2019) found a non-statistically significantly decreased risk of mortality in Ebola patients exposed to artesunate-amodiaquine during mass drug administrations as compared with Ebola patients not exposed to artesunate-amodiaquine.

Chloroquine was very recently found to potently inhibit infection of Vero E6 cells by a SARS-CoV-2 clinical isolate ($EC50 = 1.13$ µM; $CC50 > 100$ µM, $SI > 88.50$). The drug was shown to function at both entry, and at post-entry stages of the SARS-CoV-2 infection in Vero E6 cells. The EC90 value of chloroquine against SARS-CoV-2 was 6.90 µM, which can be clinically achievable as demonstrated in the plasma of rheumatoid arthritis patients who received 500 mg administration. The data therefore suggest that chloroquine, a cheap and safe drug, is potentially clinically applicable against COVID-19.

Subsequently, Yao (Clin Inf Dis 2020, see ***below***) found hydroxychloroquine ($EC50=0.72$ µM) to be more potent than chloroquine ($EC50=5.47$ µM) *in vitro*. Based on physiologically-based pharmacokinetic models results, a loading dose of 400 mg twice daily of hydroxychloroquine sulfate given orally, followed by a maintenance dose of 200 mg given twice daily for 4 days would be recommended for SARS-CoV-2 infection, as it reached three times the potency of chloroquine phosphate when given 500 mg twice daily 5 days in advance. Similar results were reported by Liu (Cell Discov 2020, see ***below***). At all conditions tested (MOI of 0.01, 0.02, 0.2, and 0.8), the EC50 for chloroquine (2.71, 3.81, 7.14, and 7.36 µM) was lower than that of hydroxychloroquine (4.51, 4.06, 17.31, and 12.96 µM). The differences in EC50 values were statistically significant at an MOI of 0.01 ($P < 0.05$) and MOI of 0.2 ($P < 0.001$).

Cortegiani (J Crt Care 2020, see ***below***) identified 23 ongoing trials in China evaluating the efficacy and safety of chloroquine or hydroxychloroquine in the treatment of COVID-19 associated pneumonia. The trials varied in study design, severity of the disease in the target population and in dosing and duration of the treatment (see also https://www.nature.com/magazine-assets/d41573-020-00016-0/17663286). The first results, from more than 100 patients, were released by the China National Centre for Biotechnology Development and said to indicate that chloroquine phosphate is superior to control treatment in inhibiting the exacerbation of pneumonia, improving lung imaging findings, promoting a virus-negative conversion, and shortening the disease course, according to a news briefing (Gao BioSci Trends 2020, see ***below***). Severe adverse reactions to chloroquine phosphate were not noted in the aforementioned patients.

In order to guide and regulate the use of chloroquine in patients with COVID-19, the multicenter collaboration group of Department of Science and Technology of Guangdong Province and Health Commission of Guangdong Province for chloroquine in the treatment of novel coronavirus pneumonia recommended chloroquine phosphate tablet, 500mg twice per day for 10 days for patients diagnosed as mild, moderate and severe cases of novel coronavirus pneumonia and without contraindications to chloroquine (Zhonghua Jie He He Hu Xi Za Zhi 2020, see ***below***).

The Dutch CDC suggested to treat severe infections requiring admission to the hospital and oxygen therapy or admitted to the ICU, with chloroquine (Cortegiani J Crt Care 2020, see ***below***). However, the document also stated that treating patients only with optimal supportive care is still a reasonable option, due to lack of supportive evidence. The suggested regimen in adults consists of 600mg of chloroquine base followed by 300mg after 12 h on day 1, then 300mg × 2/die per os on days 2–5.

Huang (J Mol Cell Biol 2020, see ***below***) reported the outcome of a small randomized trial that compared a group of 10 patients, including 3 severe and 7 moderate cases, treated with chloroquine 500mg orally twice-daily for 10 days to another group of 12 patients, including 5 severe and 7 moderate cases, treated with lopinavir/ritonavir 400/100mg orally twice-daily for 10 days. Compared to the lopinavir/ritonavir group, the percentages of patients who became SARS-CoV-2 negative in the chloroquine group were slightly higher at Day 7, Day 10, and Day 14. Patients treated with chloroquine were also discharged from hospital more rapidly. The data therefore point to a superior efficacy of chloroquine. However, larger studies remain needed before solid conclusions on this topic can be drawn.

In addition, Gautret (International Journal of Antimicrobial Agents 2020: https://www.mediterranee-infection.com/wp-content/uploads/2020/03/Hydroxychloroquine_final_DOI_IJAA.pdf) reported the outcome of an open-label non-randomized clinical trial that evaluated hydroxychloroquine alone or combined with azithromycin compared to untreated patients from another centre and cases refusing the protocol. Twenty cases received treatment in this study and showed a significant reduction of the viral carriage at day 6 post inclusion compared to controls, and much lower average carrying duration than reported of untreated patients in the literature. Azithromycin added to hydroxychloroquine was significantly more efficient for virus elimination. A second open-label trial of the combination of hydroxychloroquine and azythromycin in 80 patients was also reported by the same team (Gautret Trav Med Inf Dis 2020, see ***below***).

Importantly, Perinel (Clin Inf Dis 2020, see ***below***) subsequently reported the outcome of a preliminary PK study to define the optimal dosing regimen for COVID-19 patients in ICU. Based on the authors' simulations, a loading dose of 800 mg once daily on day 1, followed by 200 mg twice daily for 7 days was proposed. Therapeutic drug monitoring was also recommended to personalize the optimal dosing regimen, as well as additional PK and PD (virological) studies.

Garcia-Cremades (Clin Pharmacol Ther. 2020, see ***below***) further investigated the topic of hydrochloroquine dosing, using available data. The authors predicted that higher hydroxychloroquine daily doses (e.g. as high as 800 mg BID), were associated with rapid rates of viral decline and increased the percentage of PCR negative patients, but could

result in increased risk of QTc prolongation (indicator of delayed ventricular repolarisation as measured by electrocardiogram).

Borba (JAMA Netw Open 2020, see ***below***) presented interim results from a double-masked, randomized, phase IIb clinical trial in adult patients hospitalized with severe disease to evaluate high vs. low dose chloroquine diphosphate. Data from 81 patients were analysed. The authors concluded that the higher chloroquine dosage should not be recommended for critically ill patients with COVID-19 because of its potential safety hazards, especially when taken concurrently with azithromycin and oseltamivir.

However, a report based on data from the U.S. FDA's Adverse Event Reporting System (FAERS) concluded that (hydroxy)chloroquine use was not associated with a safety signal (Sarayani Res Social Adm Pharm 2020, see ***below***). Azithromycin used alone was associated with TdP/QT prolongation events.

Of note, hydroxychloroquine is also considered for **pre-exposure prophylaxis**. A randomized, double-blind, controlled study has been initiated in China in 1000 subjects to evaluate the effectiveness and safety of hydroxychloroquine for prophylaxis of COVID-19. The study enrols pre-screened healthy subjects with negative COVID-19 nucleic acid test and antibody test (http://www.chictr.org.cn/showprojen.aspx?proj=51437). A similar study is planned in the UK in 10 000 healthcare workers, or other individuals at significant risk, with chloroquine phosphate (https://clinicaltrials.gov/ct2/show/NCT04303507?term=healthy+coronavirus&recrs=abdf&type=Intr&draw=2&rank=11), and another one in Mexico in 400 health care workers with hydroxychloroquine (https://clinicaltrials.gov/ct2/show/NCT04318015?term=healthy+coronavirus&recrs=abdf&type=Intr&draw=2&rank=20).

Arbidol

Arbidol (umifenovir), which is currently used as an antiviral in Russia and China, has been reported to have inhibitory effects on a diverse array of viruses. Studies aimed at determining the mechanism of action of arbidol implicate a number of possible antiviral effects, including several steps of entry as well as later phases of the infectious cycle. According to a communication of the China National Center for Biotechnology Development at a press conference, the drug has been added to the list of possible treatments of COVID-19 in the sixth edition of the treatment and diagnosis plan published by the Chinese National Health Commission (https://www.thestar.com.my/news/regional/2020/02/18/chinese-experts-confirm-antimalarial-drug-is-effective-on-covid-19-infection).

Deng (J Inf 2020, see ***below***) presented the results of a retrospective cohort study in 33 adults with laboratory-confirmed COVID-19 without invasive ventilation. The authors concluded that combined oral **arbidol** (at a dose of 200mg every 8 h) and lopinavir/ritonavir therapy was associated with a significant elevated negative conversion rate of COVID-19 RT-PCR at 7-day and 14-day, compared with lopinavir/ritonavir only. The combination therapy was also associated with a significantly improved the chest CT scans at the 7-day timepoint. However, data have to be interpreted with caution considering the non-randomized design of the study and its small size.

A non-randomized clinical study that compared arbidol to lopinavir/ritonavir in 50 patients concluded in the superiority of arbidol. Patients in the arbidol group had a shorter duration of positive RNA test compared to those in the lopinavir/ritonavir group (P<0.01) (Zhu J Inf 2020, see ***below***).

Teicoplanin

Teicoplanin, a glycopeptide antibiotic routinely used in the clinic to treat bacterial infection with low toxicity, had been previously reported to significantly inhibit the invasion of cells by Ebola virus, SARS-CoV and MERS-CoV, via specific inhibition of the activity of cathepsin L. The efficacy of teicoplanin against SARS-CoV-2 infection was recently tested: teicoplanin was found to potently prevent the entrance of S-HIV luc pseudoviruses into the cytoplasm, with an IC50 of 1.66 µM. Although the inhibitory effect upon replication of wildtype viruses *ex vivo* and *in vivo* remains to be

determined, these preliminary result support a potential antiviral activity of teicoplanin (Zhang on BioRixv: https://www.biorxiv.org/content/10.1101/2020.02.05.935387v1).

Nafamostat

Nafamostat, an anticoagulant, is a potent inhibitor of MERS-CoV, preventing membrane fusion. The drug has been found inhibitive against SARS-CoV-2 *in vitro* infection (EC50 = 22.50 µM, CC50 > 100 µM, SI > 4.44) (Wang Cell Res 2020, see ***below***).

EK1

Peptide OC43-HR2P, derived from the HR2 domain of human CoV OC43, has been shown to exhibit broad fusion inhibitory activity against multiple human CoVs. EK1, the optimized form of OC43-HR2P, showed substantially improved pan-CoV fusion inhibitory activity and pharmaceutical properties (Xia Sci Adv 2019, see ***below***). Crystal structures indicated that EK1 can form a stable six-helix bundle structure with both short α-HCoV and long β-HCoV HR1s, further supporting the role of HR1 region as a viable pan-CoV target site. Intranasal application of EK1 peptide before or after viral challenge can protect human DPP4-transgenic mice from MERS-CoV infection (Jiang Em Micr Inf 2020, see ***below***). The potential prophylactic and therapeutic efficacy of EK1 against SARS-CoV-2 infection remains to be evaluated.

Xia (Cell Res 2020, see ***below***) subsequently generated a series of lipopeptides derived from EK1 and found that **EK1C4** was the most potent fusion inhibitor against SARS-CoV-2 S protein-mediated membrane fusion and pseudovirus infection with IC50s of 1.3 and 15.8 nM, about 241- and 149-fold more potent than the original EK1 peptide, respectively. EK1C4 was also highly effective against membrane fusion and infection by other human coronavirus pseudoviruses. Intranasal application of EK1C4 before or after challenge with HCoV-OC43 protected mice from infection.

Niclosamide

Niclosamide, an FDA-approved anthelminthic drug, was found to be effective against various viral infections with nanomolar to micromolar potency such as SARS-CoV, MERS-CoV, Zika virus, hepatitis C virus and human adenovirus, indicating its potential activity against SARS-CoV-2 (Xu ACS Infect Dis 2020, see ***below***). However, experimental data with SARS-CoV-2 have not been reported yet.

Baricitinib

Using an Artificial Intelligence-derived knowledge graph, queried by a suite of algorithms, Stebbing (Lancet Inf Dis 2020, see ***below***) also identified a group of approved drugs that could inhibit clathrin-mediated endocytosis and thereby inhibit viral infection of cells. The drug targets are members of the numb-associated kinase (NAK) family, including the AP2-associated protein kinase 1 (AAK1) and GAK, the inhibition of which has been shown to reduce viral infection *in vitro*. Baricitinib was identified as a NAK inhibitor. Baricitinib, which also binds the cyclin G-associated kinase, another regulator of endocytosis. Further, baricitinib is a potent and selective JAK inhibitor and powerful anti-inflammatory. Because the plasma concentration of baricitinib on therapeutic dosing (either as 2 mg or 4 mg once daily) is sufficient to inhibit AAK1, Richardson (Lancet 2020, see ***below***) suggested it could be trialled, using an appropriate patient population with COVID-19 acute respiratory disease (see ***JAK-STAT inhibitors*** below for information on clinical trials of baricitinib).

Camostat mesylate

The *in vitro* data reported by Koffmann (Cell 2020, see *Error! Reference source not found.*) suggested that the Japanese d rug camostat mesylate (trade name: Foipan), a TMPRSS2 inhibitor, might constitute a treatment option for COVID-19.

RNA-dependent RNA polymerase inhibitors

Nucleoside analogues commonly target viral replication, particularly the viral DNA or RNA polymerase, and have succeeded clinically in treating multiple viral infections (Agostini mBio 2018, see ***below***). However, identification and

development of antiviral nucleosides against coronaviruses have been hampered by the presence of the unique CoV proofreading 3'-5'exoribonuclease (ExoN). While nucleoside analogues such as BCX4430 inhibit CoVs, several previously tested nucleoside analogues have been incapable of potently inhibiting CoV replication, and others have demonstrated poor selectivity indexes. CoV resistance to the mutagens 5-fluorouracil and ribavirin *in vitro* is attributed to their removal by the proofreading ExoN, supporting the hypothesis that an effective nucleoside analogue must evade proofreading to successfully interfere with CoV RNA synthesis.

Remdesivir

Remdesivir (GS-5734) is the monophosphoramidate prodrug of the C-adenosine nucleoside analogue GS-441524 (Agostini mBio 2018, see ***below***). This drug candidate had been shown to inhibit *in vitro* infections with SARS-CoV, MERS-CoV, and bat CoV strains that are capable of replicating in primary human airway epithelial cells and mediate entry using human CoV receptors. Remdesivir (EC50 = 0.77 µM; CC50 > 100 µM; SI > 129.87) potently blocked infection of Vero E6 cells by a clinical isolate of SARS-CoV-2 at low-micromolar concentration and showed high selectivity index[17] (Wang Cell Res 2020, see ***below***).

In vivo, remdesivir demonstrated both prophylactic and therapeutic efficacy against SARS-CoV disease in a mouse model. In a Ces1c-/- hDPP4 mouse model of MERS-CoV infection, both prophylactic and therapeutic use of remdesivir improved pulmonary function and reduced lung viral loads and severe lung pathology (Sheahan Nat Commun 2020, see ***below***). Therapeutic remdesivir treatment 12h post-inoculation with MERS-CoV resulted in reduction in clinical signs, reduced virus replication in the lungs, and decreased presence and severity of lung lesions (de Wit PNAS 2020, see ***below***).

Remdesivir has been evaluated in a phase 2/3 controlled safety and efficacy clinical trial for the treatment of people with Ebola virus disease, which also tested 3 Ebola-specific monoclonal antibody (mAb) candidates (NCT03719586, https://clinicaltrials.gov/ct2/show/NCT03719586?term=remdesivir&draw=2&rank=1). The results of an interim analysis showed superiority of two of the mAb-based treatments over remdesivir with respect to mortality, and the trial was continued without a remdesivir arm (Mulangu New Engl J Med 2019, see ***below***). In this study, 175 patients received remdesivir. One serious adverse event was determined to be possibly related to remdesivir: a patient in this study group had hypotension that resulted in cessation of a loading dose of remdesivir and that was followed rapidly by cardiac arrest. Another clinical trial of remdesivir assessed its antiviral activity, longer-term clearance of Ebola virus, and safety in male Ebola survivors with evidence of Ebola virus persistence in semen (NCT02818582, https://clinicaltrials.gov/ct2/show/NCT02818582?term=GS-5734&draw=2&rank=1). Data from this study have not been published yet.

Remdesivir inhibits murine hepatitis virus (MHV) with similar 50% effective concentration values (EC50) as SARS-CoV and MERS-CoV (Agostini mBio 2018, see ***below***), and this model was used to assess virus resistance to remdesivir. Passage of wild type MHV in the presence of the remdesivir parent nucleoside selected two mutations in the nsp12 polymerase at residues conserved across all CoVs that conferred up to 5.6-fold resistance to remdesivir, as determined by EC50. The resistant viruses were unable to compete with wild type virus in direct coinfection passage in the absence of remdesivir. Introduction of the MHV resistance mutations into SARS-CoV resulted in the same *in vitro* resistance phenotype and attenuated SARS-CoV pathogenesis in a mouse model. Finally, an MHV mutant lacking ExoN proofreading was found significantly more sensitive to remdesivir. Combined, the results indicate that remdesivir interferes with the nsp12 polymerase even in the setting of intact ExoN proofreading activity and that resistance can be overcome with increased, nontoxic concentrations of the drug candidate.

[17] Importantly, in the same study, high concentrations of three nucleoside analogs including ribavirin, penciclovir and favipiravir were required to reduce viral infection

An overview of the various arguments supporting the use of remdesivir to treat COVID-19 has also been made available by Ko (Int J Antimicrob Ag, see ***below***).

Gilead announced that they are working with health officials in China to conduct a randomized controlled clinical trial of the experimental antiviral remdesivir for safely treating SARS-CoV-2 infections (https://www.gilead.com/news-and-press/company-statements/gilead-sciences-statement-on-the-company-ongoing-response-to-the-2019-new-coronavirus). Phase 3 randomized controlled trials to evaluate intravenous remdesivir for COVID-19 (NCT04252664 and NCT04257656) will be completed respectively, in April 2020 and May 2020, in China (Zhang J Med Vir 2020: https://onlinelibrary.wiley.com/doi/abs/10.1002/jmv.25788). Remdesivir (100 mg dose except for the first day of 200 mg) for ten days may raise safety concerns in China (due to differences in ethnicity).

A phase 3 double-blind, placebo-controlled trial of the drug is also ongoing in 440 patients in the U.S. (https://clinicaltrials.gov/ct2/show/NCT04280705?term=remdesivir&cond=covid-19&draw=2).

Grein (NEJM 2020, see ***below***) analysed the data of patients hospitalized for severe COVID-19 who were treated with compassionate-use remdesivir in the United States, Europe, Canada, and Japan. Clinical improvement was observed in 36 of 53 patients (68%). Mortality reached 18% (6 of 34) among patients receiving invasive ventilation and 5% (1 of 19) among those not receiving invasive ventilation.

Of note, Choy (Antivir Res 2020, see ***below***) demonstrated that a combination of remdesivir and emetine showed synergistic effect *in vitro* and suggested that combinational therapy may help reduce the effective concentration of compounds below the therapeutic plasma concentrations and provide better clinical benefits.

Ribavirin

While *in vitro* data have not identified ribavirin as a lead candidate, a randomized clinical trial of the drug used in combination with pegylated interferon has been reported in China for COVID-19 (ChiCTR2000029387) (https://www.nature.com/magazine-assets/d41573-020-00016-0/17663286). (Zhang J Med Vir 2020: https://onlinelibrary.wiley.com/doi/abs/10.1002/jmv.25788) indicated that ribavirin was indicated for the general treatment of COVID-19 in Chinese treatment guidelines, and combination with interferon recommended. However, their clinical safety and efficacy against COVID-19 were not evaluated in China.

Favipiravir

Randomized trials of favipiravir have been reported in China for COVID-19 therapy (ChiCTR2000029544, ChiCTR2000029600) ((https://www.nature.com/magazine-assets/d41573-020-00016-0/17663286). On March 17, Zhang Xinmin released in the media data from a Chinese trial that evaluated favipiravir (http://www.chinadaily.com.cn/a/202003/17/WS5e708666a31012821727fcbd.html)**.** The Third People's Hospital of Shenzhen in Guangdong province conducted a clinical trial on 80 patients, with 35 receiving the drug. The results showed that patients treated with favipiravir took four days before being tested negative, whereas the control group took 11 days. The lung conditions of 91.43 percent of the treated group improved as shown in chest imaging, compared with 62.22 percent of the control group. In another comparative trial on 120 patients conducted by Zhongnan Hospital of Wuhan University, the results were said to have shown that the treated group had a higher recovery rate at the end of treatment and took less time to reduce fever and relieve cough. Scientific publication of these data is now awaited.

Other RNA-dependent RNA polymerase inhibitors

Lung (J Med Vir 2020, see ***below***) screened chemical structures from traditional Chinese medicinal compounds proven to show anti-viral activity in SARS-CoV and similar chemical structures through a molecular docking study to target the RNA-dependent RNA polymerase (RdRp) of SARS-CoV-2, SARS-CoV and MERS-CoV. Theaflavin was identified as a potential SARS-CoV-2 RdRp inhibitor.

Protease inhibitors

Involved in the formation of the coronavirus replication complex, the viral main protease (3-chymotrypsin-like cysteine protease, 3CLpro, also called Mpro) represents an attractive target for therapy. The structure of Mpro has been resolved and made publicly available to facilitate global efforts to develop novel drug candidates.

Lopinavir/ritonavir

Lopinavir and ritonavir are used as a combination therapy for the treatment and prevention of HIV/AIDS. However, they soon appeared as candidate of choice for COVID-19 therapy. Yao (J Med Vir 2020, see ***below***) published a review of the literature on the efficacy of lopinavir *in vitro* and *in vivo*, especially in patients with SARS and MERS.

Lin (manuscript on MedRxiv: https://www.biorxiv.org/content/10.1101/2020.01.31.929695v2.full.pdf) presented evidence supporting the mode of action of lopinavir, ritonavir and dapunavir through their predicted interactions with SARS-CoV-2 proteases. He suggested that the therapeutic effect of ritonavir and lopinavir on COVID-19 may be mainly due to their inhibitory effect on coronavirus endopeptidase C30, with ritonavir appearing to have stronger efficacy; the inhibitory effect of darunavir on SARS-CoV-2 and its potential therapeutic effect may be mainly due to its inhibitory effect on papain-like viral protease.

Several clinical trials are currently ongoing to evaluate lopinavir and/or ritonavir (± other drug candidates) in COVID-19 (see for instance study NCT04252885: https://clinicaltrials.gov/ct2/show/NCT04252885?term=lopinavir&recrs=ab&draw=2&rank=3, or NCT04255017: https://clinicaltrials.gov/ct2/show/NCT04255017?term=lopinavir&recrs=abd&draw=2&rank=7).

Cao (NEJM 2020, see ***below***) reported the outcome of an open-label trial involving hospitalized adult patients with confirmed SARS-CoV-2 infection in Wuhan. 199 patients were randomly assigned in a 1:1 ratio to receive either lopinavir-ritonavir (400 mg and 100 mg, respectively) twice a day for 14 days, in addition to standard care, or standard care alone. Treatment with lopinavir-ritonavir was not associated with a difference from standard care in the time to clinical improvement (hazard ratio for clinical improvement, 1.24; 95% confidence interval [CI], 0.90 to 1.72). Mortality at 28 days was similar in the lopinavir-ritonavir group and the standard-care group (19.2% vs. 25.0%; difference, -5.8 percentage points; 95% CI, -17.3 to 5.7). The percentages of patients with detectable viral RNA at various time points were similar. Moreover, lopinavir-ritonavir treatment was stopped early in 13 patients (13.8%) because of adverse events. The interpretation of these data in the editorial by Baden (NEJM 2020, see ***below***) is also of interest. For instance, it highlighted the fact that patients recruited for this study were late in infection and already had considerable tissue damage.

Other candidates targeting Mpro

Zhang (https://www.biorxiv.org/content/10.1101/2020.02.17.952879v1) determined the crystal structure of the unliganded Mpro at 1.75 A resolution and used this structure to guide optimization of a series of **alpha-ketoamide inhibitors**. The main goal of the optimization efforts was improvement of the pharmacokinetic properties of the compounds.

Using a computational strategy, based on the synergy of virtual screening, docking and molecular dynamics techniques, Macchiagodena (on ArXiv: https://arxiv.org/abs/2002.09937) identified lead compounds for the non-covalent inhibition of Mpro of SARS-CoV-2. Ligands were found to share a common binding pattern with aromatic moieties connected by rotatable bonds in a pseudo-linear arrangement. Molecular dynamics calculations confirmed the stability in the Mpro binding pocket of most potent binder identified by docking, namely a **chlorophenyl-pyridyl-carboxamide derivative.**

Tahir ul Qamar (manuscript on Preprints: https://www.preprints.org/manuscript/202002.0193/v1) analysed the Mpro sequence, constructed a 3D homology model, and screened it against a **medicinal plant** library containing 32 297 potential anti-viral phytochemicals/traditional Chinese medicinal compounds. These analyses revealed nine hits that

may serve as potential anti-SARS-CoV-2 lead molecules for further optimisation and drug development to control COVID-19.

Ton (Mol Inf 2020, see ***below***) developed a novel deep learning platform - Deep Docking (DD) which provides fast prediction of docking scores of Glide (or any other docking program) and, hence, enables structure-based virtual screening of billions of purchasable molecules in a short time. The authors applied DD to all 1.3 billion compounds from ZINC15 library to identify top 1000 potential ligands for SARS-CoV-2 Mpro protein.

From an *in silico* study by Kandeel (Life Sci 2020, see ***below***), ribavirin, anti-hepatitis B virus (telbivudine), two vitamins (vitamin B12 and nicotinamide) and other miscellaneous systemically acting drugs were identified as potential blockers of SARS-CoV-2 Mpro.

Jin (Nature 2020, see ***below***) assayed over 10,000 compounds including approved drugs, drug candidates in clinical trials, and other pharmacologically active compounds as inhibitors of Mpro. Six of these compounds inhibited Mpro with IC50 values ranging from 0.67 to 21.4 µM. **Ebselen** also exhibited promising antiviral activity in cell-based assays.

Danoprevir

Chen (manuscript on MedRxiv: https://www.medrxiv.org/content/10.1101/2020.03.22.20034041v1.full.pdf) reported on the first clinical study using Danoprevir (Ganovo®), an HCV protease inhibitor marketed in China since 2018, combined with Ritonavir (NCT04291729), in the presence or absence of α-interferon nebulization. The data from this small study suggested that the combination is well tolerated by COVID-19 patients (moderate cases included). After 4 to 12-day treatment, all eleven patients enrolled were discharged from the hospital.

Other drug candidates

Nitazoxanide

Nitazoxanide, a commercial antiprotozoal agent with antiviral potential against a broad range of viruses including human and animal coronaviruses, inhibited infection of Vero E6 cells by a clinical isolate of SARS-CoV-2 at a low-micromolar concentration (EC50 = 2.12 µM; CC50 > 35.53 µM; SI > 16.76). Further *in vivo* evaluation of this drug against SARS-CoV-2 infection was recommended by Wang (Cell Res 2020, see ***below***).

Ivermectin

As the epidemic continues to progress, more and more compounds are described as potential therapeutics with antiviral activity against SARS-CoV-2. For instance, ivermectine (Caly Antivir Res 2020, see ***below***), a widely-approved anti-parasitic previously shown to have broad-spectrum anti-viral activity *in vitro*, has been found to inhibit SARS-CoV-2, with a single addition to Vero-hSLAM cells 2 hours post infection with SARS-CoV-2 inducing a ~5000-fold reduction in viral RNA at 48 h. Of note, the much higher required dosage for the antiviral as compared to the antiparasitic effects of the drug seriously hampers the likelihood of further development of this compound against COVID-19.

Biological response modifiers

Biological response modifiers (BRM) are substances that interact with and modify the host immune system by acting on a therapeutic target considered important in the pathogenic process of the disease (Lacoma Front Imm 2019). They are now established as therapies for malignancies, transplant rejection, as well as several immune disorders, and can also provide protection against infectious diseases. They include immunostimulatory agents capable of enhancing host defence mechanisms, as well as compounds offering protection against the negative consequences of immune responses. They include antimicrobial peptides, therapeutic small molecules, therapeutic antibodies, cytokines and other immumodulators. Controlling cytokine production and inflammatory response appears as a desirable objective, given that they are responsible for the accumulation of cells and fluids. However, as pointed out by Li (J Med Virol 2020, see ***below***), this strategy remains challenging as long as immune response parameters that can be inhibited

specifically without compromising the beneficial host defence have not been identified. For instance, completely blocking a proximal event in the immune response (e.g., activation of interferon response-related pattern recognition receptors) seems unwise considering its general role in regulating host defence.

Interferon-α

During the SARS outbreak in 2003, an animal study revealed that recombinant human IFN-α2b spray can prevent SARS CoV infection in Rhesus monkey model by inhibiting virus infection and replication (Shen World J Pediatr 2020, see ***below***). Further clinical evaluation revealed that recombinant human IFN-α2b spray can effectively reduce the infection rate of respiratory syncytial virus, influenza virus, adenovirus and SARS-CoV. The "Novel Coronavirus Infection Pneumonia Diagnosis and Treatment Standards (fourth edition) and Diagnosis, treatment and prevention of 2019 novel coronavirus infection in children: experts' consensus statement" of the National Health Commission of People's Republic of China also listed IFN-α atomization as a treatment option for COVID-19 pneumonia. An ongoing clinical trial in China evaluates the **preventive** effect of recombinant human interferon-α nasal drops on SARS-CoV-2 infection in medical staff (NCT04320238, https://clinicaltrials.gov/ct2/show/NCT04320238?term=healthy+coronavirus&recrs=abdf&type=Intr&draw=2).

Anti-inflammatory therapies

Corticosteroids

Corticosteroids were widely used during the outbreaks of SARS and MERS CoVs and are being used in patients with COVID-19 in addition to other therapeutics. However, current interim guidance from WHO on clinical management of severe acute respiratory infection when novel coronavirus (COVID-19) infection is suspected (https://www.who.int/docs/default-source/coronaviruse/clinical-management-of-novel-cov.pdf) advises against the use of corticosteroids unless indicated for another reason. The same conclusion was reported by Russell (Lancet 2020, see ***below***) who concluded from a literature review that no unique reason exists to expect that patients with COVID-19 will benefit from corticosteroids, and that they might be more likely to be harmed with such treatment. However, a subsequent publication by Shang (Lancet 2020, see https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930361-5) noted that the existing evidence on this topic is inconclusive, and even systematic reviews and metaanalyses on this topic reached differing conclusions. The authors recommended short courses of corticosteroids at low-to-moderate dose, used prudently, for critically ill patients with COVID-19 pneumonia. A similar recommendation was made by Zhou (Signal Transduct Target Ther 2020, see ***below***).

Anti-IL6 receptor

IL-6 may play a role in driving the overactive inflammatory response in the lungs of patients who are severely or critically ill with COVID-19. A single-arm study of tocilizumab (Actemra), a humanized recombinant monoclonal antibody directed against the IL-6 receptor, in 21 Chinese patients with severe pneumonia provided preliminary data supporting the role of IL-6 in COVID-19 (https://sfar.org/download/effective-treatment-of-severe-covid-19-patients-with-tocilizumab/). Another report by Luo (J Med Vir 2020, see ***below***) described a retrospective observational study of tocilizumab in 15 patients. Although treatment ameliorated the increased CRP in all patients rapidly, for the 4 critically ill patients who received only single dose of tocilizumab, 3 of them died and the CRP level in the last patient failed to return to normal range with a clinical outcome of disease aggravation. Serum IL-6 level tended to further spike first and then decreased after tocilizumab therapy in 10 patients. A persistent and dramatic increase of IL-6 was observed in the 4 patients with treatment failure.

The Italian Medicines Agency (AIFA) announced on March 19 the launch of TOCIVID-19, an independent phase 2 open label study to evaluate the efficacy and safety of tocilizumab in the treatment of pneumonia during COVID-19. https://clinicaltrials.gov/ct2/show/NCT04317092?term=tocilizumab&cond=covid-19&draw=2&rank=1. A phase 3 double blind, placebo-controlled clinical study is planned (https://clinicaltrials.gov/ct2/show/NCT04320615?term=tocilizumab&cond=covid-19&draw=2&rank=2).

Preliminary findings from a randomized trial evaluating tocilizumab in France were disclosed on April 27 (https://www.aphp.fr/contenu/tocilizumab-improves-significantly-clinical-outcomes-patients-moderate-or-severe-covid-19). Patients were selected on the basis of being hospitalized for COVID-19 moderate or severe pneumonia not requiring intensive care upon admission. The primary composite outcome was need for ventilation (non-invasive or mechanical) or death at day 14. A total of 129 patients were randomized: 65 to standard of care + tocilizumab and 64 to standard of care alone. A significantly lower proportion of patients reached the primary outcome in the tocilizumab arm.

Sarilumab (Kevzara) is a fully-human monoclonal antibody that inhibits the IL-6 pathway by binding and blocking the IL-6 receptor. An adaptive phase 2/3, randomized, double-blind, placebo-controlled study assessing the efficacy and safety of Sarilumab for hospitalized patients with COVID-19 is ongoing in the U.S. (https://clinicaltrials.gov/ct2/show/NCT04315298?term=kevzara&cond=covid-19&draw=2&rank=1). Additional trials are planned in other countries.

JAK-STAT inhibitors

Baricitinib is a powerful anti-inflammatory that, as a JAK-STAT signalling inhibitor, is likely to be effective against the consequences of the elevated levels of cytokines observed in people with severe COVID-19. Richardson (Lancet Inf Dis 2020, see ***below***) further acknowledged that that using a JAK1 and JAK2 inhibitor to treat a viral disease might appear illogical given that the antiviral effects of interferons are largely mediated by the JAK–STAT signalling pathway. However, the authors do not recommend that baricitinib or other JAK inhibitors be given to individuals at an early stage of infection. Clinical trials assessing the efficacy of baricitinib to treat COVID-19 are ongoing (NCT04320277) or planned (NCT04321993).

In a pilot uncontrolled trial, baricitinib at 4 mg/day/orally (combined with lopinavir-ritonavir) was given to 12 pneumonia patients with moderate COVID-19 (Cantini J Infect 2020, see ***below***). No adverse events were recorded, after 2 weeks in treated patients. Clinical and respiratory parameters significantly improved at 2 weeks. None of the baricitinib-treated patients required admission to ICU.

Immune checkpoint inhibitors

Immune checkpoint inhibitors are being considered for their potential to augment the host response in sepsis. PD-1 and PD-L1 are indeed key mediators in T cell depletion in sepsis patients. Animal models have shown that blocking PD-1 or PD-L1 can prevent T cell death, regulate cytokine production, reduce organ dysfunction and reduce death in sepsis. Previous experience showed the clinical safety of anti-PD-1 antibody in sepsis patients through randomized, placebo-controlled trials. A phase 2 clinical trial is currently planned in 120 COVID-19 patients to evaluate anti-PD-1 antibody treatment vs. thymosin vs. control (NCT04268537, https://clinicaltrials.gov/ct2/show/NCT04268537?term=anti-PD-1&cond=COVID-19&draw=2&rank=1).

BTK inhibitors

Based on observations in 5 patients on ibrutinib, Treon (Blood 2020, see ***below***) suggested that ibrutinib and possibly other BTK-inhibitors may provide protection against lung injury, and even improve pulmonary function in hypoxic patients with COVID-19.

Renin–Angiotensin–Aldosterone System inhibitors

Placebo-controlled clinical trials of **losartan**, an angiotensin-receptor blocker, as a treatment for COVID-19 are being conducted among patients who have not previously received treatment with a Renin–Angiotensin–Aldosterone System inhibitor and are either hospitalized (NCT04312009) or not hospitalized (NCT04311177) (Vaduganathan NEJM 2020, see ***below***).

Other therapeutic antibodies

Several other antibodies specific for host targets that are developed in the context of lung disease might appear as promising for COVID-19 therapy. Some antibodies may indeed have the potential to reduce prolonged damaging cellular infiltration during severe lung infections (Elbahesh Front Imm 2019). For instance, angiopoietin-like 4 (ANGPTL4) is a soluble angiogenic regulating protein. Following proteolytic cleavage, the C-terminal portion (cANGPTL4) is involved in integrin-dependent wound repair and can regulate vascular permeability. ANGPTL4 is significantly elevated in lung biopsies from influenza virus-induced pneumonia patients. In mouse studies, neutralizing anti-ANGPTL4 antibodies reduced pulmonary tissue leakiness, significantly accelerating lung recovery. Vascular leakage is a hallmark of many infectious diseases, including those caused by SARS and MERS CoVs (Li Oncotarget 2015). The roles of ANGPTL4 in SARS-CoV-2 infection is still unclear, but warrant future investigations.

Antimicrobial peptides

Antimicrobial peptides (AMPs), also termed host defence peptides, can be produced as part of the host's innate immune system during an infection process (Cardoso Int J Mol Sci 2019, Brice Curr Med Chem 2019). These peptides belong to a broad group of molecules produced by many tissues and cell types in a variety of organisms, including plants, invertebrates, vertebrates, fungi and bacteria. The majority of AMPs are composed of relatively small (<10 kDa), cationic and amphipathic molecules, mostly consisting of 6 to 50 amino acid residues. The different amino acid compositions lead to structural properties in terms of amphipathicity, net positive charge, shape and size, which favour interaction with microbial surfaces, insertion into lipid bilayers and induction of membrane damage. It is therefore not surprising that human AMPs display activity against enveloped viruses as well as bacteria and fungi (Brice Curr Med Chem 2019). However, these peptides also exhibit activity against a wide range of non-enveloped viruses, acting at a number of different steps in viral infection. Recent studies have begun to elucidate the antiviral properties of AMPs as well as their role in regulation of inflammation and chemoattraction. AMPs have been suggested as promising therapies against viral pathogens (Ahmed Viruses 2019), even though experimental data are still needed to support this proposal.

The antiviral activity of **defensins**, a class of AMPSs, was first reported in 1986. Since then, defensins have demonstrated *in vitro* effects against HIV, influenza A virus, human adenovirus, human papillomavirus, RSV, herpes simplex virus and SARS-CoV. However, few studies in animal models of virus infection have been reported. A murine β-defensin 1-deficient mouse model showed that MBD1, the murine counterpart of HBD1, participated in the protection of mice from influenza infection via a mechanism other than the inhibition of viral replication (Park 2018). Innovation Pharmaceuticals has announced the consideration of its defensin mimetic drug candidate **Brilacidin** for the potential treatment of Covid-19, the disease caused by the coronavirus (https://www.pharmaceutical-technology.com/news/innovation-pharmaceuticals-covid-19-drug/). Brilacidin is a small molecule in late-phase development. The drug is said to have shown antibacterial, anti-inflammatory and immunomodulatory activity in different clinical studies.

Cell-based therapies

A rapidly increasing number of clinical investigations of cell-based therapy approaches for COVID-19 is reported. These utilise a range of different cell sources, doses, dosing strategies, and targeted patient populations. To provide a rational strategy to maximise potential therapeutic use, Khoury (Eur Respir J 2020, see ***below***) recommended a good understanding of the relevant pre-clinical studies and postulated mechanisms of actions in respiratory virus-induced lung injuries.

Mesenchymal stem cells

Mesenchymal stem cells (MSCs) have been widely used in cell-based therapy, from basic research to clinical trials. Safety and effectiveness have been clearly documented in many clinical trials, especially in the immune-mediated inflammatory diseases, such as graft versus-host disease and systemic lupus erythematosus. MSCs play a positive role mainly in two ways, namely immunomodulatory effects and differentiation abilities. MSCs can secrete many types of

cytokines by paracrine secretion or make direct interactions with immune cells, leading to immunomodulation. The immunomodulatory effects of MSCs are triggered further by the activation of TLR receptor in MSCs, which is stimulated by pathogen-associated molecules such as LPS or double-stranded RNA. A review by provides a rationale to the use of such therapy in COVID-19 patients.

In a pilot study (ChiCTR2000029990), MSCs transplantation could cure or improve the functional outcomes of seven patients without observed adverse effects (Leng Aging Dis 2020, see ***below***). The pulmonary function and symptoms of these patients were significantly improved in 2 days after MSC transplantation. Among them, two common and one severe patient were recovered and discharged in 10 days after treatment. After treatment, the peripheral lymphocytes were increased, the CRP decreased, and the overactivated cytokine-secreting immune cells CXCR3+CD4+ T cells, CXCR3+CD8+ T cells, and CXCR3+ NK cells disappeared in 3-6 days. In addition, a group of CD14+CD11c+CD11bmid regulatory DC cell population dramatically increased. Meanwhile, the level of TNF-α was significantly decreased, while IL-10 increased in MSC treatment group compared to the placebo control group. Furthermore, the gene expression profile showed MSCs were ACE2- and TMPRSS2- which indicated MSCs are free from COVID-19 infection. Several larger trials of this therapy are currently either ongoing or planned in China and other countries (Brazil, Jordan, France).

High-Dose Intravenous Immunoglobulin

Cao (Open Forum Infect Dis 2020, see ***below***) reported on the use of high-dose Intravenous Immunoglobulin at 0.3–0.5 g per kg weight per day for five days in 3 patients with deteriorating condition. None of the 3 patients reported any adverse events. All patients were clinically improved shortly after the administration, with their temperature back to normal in 1-2 days and breathing difficulties alleviating in 3-5 days. Confounding factors did exist, including the use of different antivirals in 2 of the 3 patients at various time points and a short course of steroids in patient 3.

Information from comparative trials

Shi (J Med Vir 2020, see ***below***) reported on a small randomized clinical trial in 184 patients in Shangai. All patients received symptomatic treatment. They were divided into 7 groups: the Symptomatic treatment group (n=17), arbidol group, lopinavir/ritonavir group, arbidol+lopinavir/ritonavir group, Interferon group, interferon+lopinavir/ritonavir group, and interferon+darunavir group. Antiviral treatment duration was 5 days. No significant differences were found among the groups in terms of the proportion of patients with pneumonia resolution (P=0.151) after treatment or the length of hospital stay (P=0.116).

Antibodies

Polyclonal antibodies

Convalescent plasma

The effectiveness of convalescent plasma for the treatment of SARS, as reviewed by Mair-Jenkins (J Infect Dis 2015, see ***below***), was assessed by 8 studies reporting outcomes for 214 patients with SARS in total. The absolute reduction in the risk of mortality varied from 7% (95% CI, -2.39 to 18.68) to 23% (95% CI, 5.59–42.02) in 2 studies at medium to high risk of bias. Subgroup analyses suggested that early treatment was beneficial. Four non-comparative studies found that the case-fatality rate varied from 0% (0/1) to 12.5% (10/80) in treated subjects. Increased antibody levels were detected up to day 5 after treatment in 1 study of HCWs (which was at high risk of bias). Experience with convalescent plasma infusion has also been obtained in the context of MERS-CoV infections. Ko (Antivir Ther 2018, see ***below***), based on experience with 3 patients, suggested that for effective convalescent plasma infusion against MERS, donor plasma with a neutralization activity (PRNT titre) ≥1:80 should be used. However, the observation that convalescent plasma infusion led to possible transfusion-related acute lung injury (TRALI) in a MERS patient in Korea suggests that convalescent plasma therapy should be cautiously approached (Chun Ann Lab Med 2016, see ***below***).

In a recent publication, Zhang (J Med Vir 2020, see ***below***) identified this approach as a potential treatment for COVID-19. Information released in the media soon indicated that the procedure was evaluated clinically in China

(https://www.scoop.it/topic/virusworld/p/4115315422/2020/02/14/china-seeks-plasma-from-recovered-patients-to-treat-virus). A plasma donation program had been launched in Zhejiang Province (http://www.xinhuanet.com/english/2020-02/19/c_138799179.htm). The plasma donated by recovered coronavirus patients was said to be used for treatment of COVID-19 patients in critical condition.

Shen (JAMA 2020, see ***below***) reported 5 critically ill patients with laboratory-confirmed COVID-19 and ARDS who received convalescent plasma with a SARS-CoV-2–specific antibody (IgG) binding titer greater than 1:1000 and a neutralization titer greater than 40 (obtained from patients who recovered from COVID-19). Following plasma transfusion, viral loads decreased and became negative within 12 days after the transfusion, and SARS-CoV-2-specific ELISA and neutralizing antibody titers increased. ARDS resolved in 4 patients at 12 days after transfusion, and 3 patients were weaned from mechanical ventilation within 2 weeks of treatment. Of the 5 patients, 3 have been discharged from the hospital, and 2 are in stable condition at 37 days after transfusion. The small sample size of the study precludes conclusions in terms of effectiveness, but data from clinical trials are expected in a near future.

Another pilot study on convalescent plasma therapy (single 200 mL dose with neutralization activity greater than 1:640) in severe COVID-19 patients was reported by Duan (PNAS 2020, see ***below***). Data showed no severe adverse events and undetectable viral load after transfusion in 7/10 patients. Ye (J Med Vir 2020, see ***below***) reported a positive outcome in 6 patients treated with convalescent plasma. Ahn (J Kor Med Sci 2020, see ***below***) reported on 2 additional cases treated with convalescent plasma in Korea with positive outcome.

The US Food and Drug Administration approved the use of plasma from recovered patients to treat people who are critically ill with COVID-19, provided that doctors get approval over the telephone (Tanne BMJ 2020, see ***below***).

Purified immune globulins

SAB-301 is a fully-human polyclonal IgG immunoglobulin (SAB-301) produced from hyperimmune plasma of transchromosomic cattle immunized with purified MERS-CoV spike protein nanoparticles vaccine (Beigel Lancet Inf Dis 2018, see ***below***). In a phase 1 trial, single infusions of SAB-301 up to 50 mg/kg appear to be safe and well-tolerated in healthy participants. Single dose pharmacokinetics (PK) demonstrated relatively linear and dose-proportional increases in maximal concentration and area-under-the-concentration-time curve ($AUC_{0–24}$), and the PK strongly correlated with the microneutralization assay. Whether SAB-301 purified immune globulin is able to neutralize SARS-CoV-2 remains unclear. Takeda announced the development of an anti-SARS-CoV-2 polyclonal hyperimmune globulin, **TAK-888**, to treat high-risk individuals with COVID-19 (https://www.takeda.com/newsroom/featured-topics/rajeev-venkayya-president-global-vaccine-business-unit-on-the-latest-on-the-coronavirus-and-takeda/).

Monoclonal antibodies

The SARS-CoV and MERS-CoV neutralizing monoclonal antibodies (mAbs) and nanobodies with protective efficacy are specific to the S1 subunit of S protein, particularly the receptor-binding domain (RBD) (Jiang Em Micr Inf 2020, see ***below***). Therefore, the SARS-CoV-2 S-RBD can be anticipated to be a key target for developing SARS-CoV-2- neutralizing mAbs. Neutralizing mAbs targeting non-RBD regions, including the NTD and S2 of SARS-CoV and/or MERS-CoV S could also be identified, although their neutralizing potency is generally lower than that of RBD-specific mAbs. One of the rapid approaches to develop a mAb against SARS-CoV-2 is to evaluate the currently available SARS-CoV neutralizing antibodies with cross-neutralizing and protection activity against SARS-CoV-2 infection. SARS-CoV S-RBD-specific neutralizing mAbs and sera have been shown able to cross-neutralize bat-SL-CoVs, such as bat-SL-CoV-W1V1 and bat-SL-CoV-SHC014, suggesting that they might also cross-neutralize SARS-CoV-2.

A whole range of mAbs have been listed by WHO as potential candidates against COVID-19 (https://apps.who.int/iris/bitstream/handle/10665/330680/WHO-HEO-RDBlueprint%28nCoV%29-2020.1-eng.pdf?ua=1) (Table 12). Their ability to neutralize SARS-CoV-2 *in vitro* and *in vivo* remains to be confirmed.

Table 12 Monoclonal antibodies listed by WHO as potential candidates against COVID-19

Product type and candidate	Target disease	Description	Status of development	Preliminary results
80R mAB S3.1 m396	SARS	Human monoclonal antibodies	In vitro	inhibited different SARSCoV subtypes Didn't neutralize GD03 strain
GD27 Gd33 MCA1 JC57-14 MERS-4 CDC2-C2 VHH-83, HCAb-83 CVHHs NbMs10 NbM10-Fc LCA60	MERS	HmAbs/ Fab-RBD HmAbs/ Fab-RBD HmAbs/ Fab-RBD Macaque mAbs/ FabRBD HmAbs/ Fab-RBD HmAbs/ Fab-RBD Dromedary VHHs Dromedary VHHs Dromedary VHHs Llama VHHs Llama VHHs Human survivors	In vitro and in vivo (transgenic mice)	Most of mAbs can neutralize pseudotype or live MERS-CoV and some shown protection in animal models in vivo
REGN3048 and REGN3051 antibody cocktail	MERS		Double-blind, placebo-controlled Phase I study. Single ascending dose cohorts safety, 48 subjects. NCT03301090	No results posted

A review on FcR and antibody engineering by Chenoweth (Immunol Cell Biol 2020, see ***below***) could be of particular interest to the development of therapeutic mAbs against COVID-19.

Traditional Chinese Medicine

The utilization of Traditional Chinese Medicine (TCM) in managing COVID-19 is substantial in China. All confirmed COVID-19 cases in Shanghai started integrative Chinese-Western medicine treatment (Yuan and Qiu. Forty-one patients with new coronavirus pneumonia were treated with traditional Chinese medicine. Xinhua Net, Shanghai, 2020). National guideline recommended herbal formulations according to clinical stages and severity of COVID-19. Although national/provincial/local guidelines could differ in terms of treatment strategy, most guidelines defined COVID-19 as endemic, toxic, dampness or warm infectious disease (Chan Am J Chin Med 2020, see ***below***). The six most commonly used herbs were *Astragali Radix* (Huangqi), *Glycyrrhizae Radix Et Rhizoma* (Gancao), *Saposhnikoviae Radix* (Fangfeng), *Atractylodis Macrocephalae Rhizoma* (Baizhu), *Lonicerae Japonicae Flos* (Jinyinhua), and *Forsythiae Fructus* (Lianqiao). Some of them are the core components of classical herbal formula: Yupingfeng san (powder), for tonifying qi to protect from external pathogens, and Yinqiao san (powder), used to prevent and treat respiratory infectious diseases (Luo Chin J Integr Med 2020, see ***below***).

Between 23 January and 8 March 2020, 382 new trials related to management of patients with COVID-19 were registered on the WHO's International Clinical Trials Registry Platform (ICTRP). 98 out of these 382 trials evaluate TCM, which includes 48 named TCMs, 27 unspecified methods; 18 combinations with unspecified Western therapies, and 5 others (e.g. acupuncture) (Aronson at https://www.cebm.net/oxford-covid-19/covid-19-registered-trials-and-analysis/). Among the ongoing largest COVID-19 clinical trials in terms of participant size, one trial (GDCT0379500), involving 600 participants in Hubei in China, is aiming to determine if the addition of TCM to standard health education is more effective than health education alone in preventing COVID-19 (https://www.clinicaltrialsarena.com/comment/covid-19-clinical-trials/).

Therapies targeting acute respiratory distress syndrome, sepsis, and multiple organ failure

Acute respiratory distress syndrome is a common cause of respiratory failure in critically ill patients and is defined by the acute onset of non-cardiogenic pulmonary oedema, hypoxaemia and the need for mechanical ventilation (Matthay Nat Rev Dis Primers 2019). Despite some improvements, it remains associated with a high level of mortality (30-40%) in most studies. One approach to improve disease outcome is to identify patients earlier in their clinical course, so that supportive care with lung-protective ventilation, prone positioning and a conservative fluid approach can be implemented. Up to now, pharmacological agents did not prove very helpful in the management of acute respiratory distress syndrome. A recent review (Lewis Cochrane Database Syst Rev 2019, see ***below***) found insufficient evidence to determine with certainty whether corticosteroids, surfactants, N-acetylcysteine, statins, or beta-agonists were effective at reducing mortality, or duration of mechanical ventilation, or at increasing ventilator-free days. The list of unsuccessful therapies also includes agents such as prostaglandin E1, activated protein C, anti-oxidants, omega-3 supplementation, ketoconazole, lisofylline, factor VIIa, IFN-β1α, or granulocyte macrophage-stimulating factor. However, it remains possible that the clinical trials that evaluated these products were not designed in the most suitable way.

Shi (Cell Death Diff 2020, see ***below***) suggested the use of intratracheal **hyaluronidase** to eliminate hyaluronan, known to be associated with ARDS. Even though the accumulation of hyaluronan has not been confirmed in COVID-19 cases yet, autopsies have concluded that the lungs are filled with clear liquid jelly. Aerosol administration of hyaluronidase had been considered before for ARDS (https://www.omicsonline.org/open-access/hyaluronidase-a-potential-new-treatment-for-acute-respiratory-distresssyndrome-2161-105X-1000407.php?aid=89111).

Solaimanzadeh (Cureus 2020, see ***below***) analysed clinical data published on COVID-19 in the context of another respiratory illness - high altitude pulmonary edema (HAPE). The similarities between the 2 conditions led to the recommendation to evaluate **acetazolamide**, a drug that potently reduces hypoxic pulmonary vasoconstriction, improves minute ventilation and expired vital capacity. Other therapeutics to consider that are also directed towards decreased pulmonary pressure include Nifedipine and Phosphodiesterase inhibitors.

There is evidence in both animals and humans that fibrinolytic therapy in acute lung injury and ARDS improves survival. There would be a rationale for such therapeutic approach in patients with ARDS and concomitant diagnoses of disseminated intravascular coagulation, as observed in more than 70% of those who die of COVID-19. Wang (J Thromb Haemost 2020, see ***below***) reported 3 cases of off-label intravenous administration of **tissue plasminogen activator** (Alteplase) for patients with COVID-19 suffering from ARDS and respiratory failure. In all 3 cases the patients demonstrated an initial improvement in their PaO2/FiO2 ratio, with improvements ranging from a 38% improvement to a ~100% improvement. However, the observed improvements were transient in all 3 patients.

Whereas it is reported that plasminogen is dramatically increased in adults with ARDS, Wu (QJM 2020, see ***below***) treated 13 clinically moderate, severe or critical COVID-19 patients with atomization inhalation of freeze-dried **plasminogen**. After plasminogen inhalation, conditions of lung lesions in 5 clinically moderate patients quickly improved, as shown by the decreased range and density of 'ground glass' opacity. Improvements of oxygen saturation were observed in 6 clinically severe patients. In the 2 patients with critical conditions, the oxygen levels significantly increased from 79-82% to 91% just about 1 hour after the first inhalation. In 8 of 13 patients heart rates slowed down. Furthermore, a general relief of chest tightness was observed. Overall, the study suggested that additional plasminogen may be effective and efficient in treating lung lesions and hypoxemia during COVID-19 infections. Further studies are now needed to confirm this observation.

A short review by Keith (Crit Care 2020, see ***below***) provided the rationale as well as preliminary data supporting **total plasma exchange** in patients with sepsis and multiple organ failure (not related to COVID-19). To what extent this

approach may be successful in the management of patients with the most severe forms of COVID-19 remains to be defined.

Blood purification systems

An artificial-liver blood-purification system is reported to have shown good prognosis in the treatment of severely or critically ill COVID-19 patients with cytokine storm (Zhang Engineering 2020, see ***below***). Based on the above-described evidence, the Expert Consensus on the Application of Artificial-Liver Blood-Purification System in the Treatment of Severe COVID-19 was recently released. This work recommends artificial-liver blood purification for the treatment of patients with COVID-19 infection who exhibit cytokine storm and rapid disease progression, as confirmed by lung imaging.

A relevant publication on this topic is also the report by Akil (Thorac cardiovasc Surg 2020, see ***below***) of a small study conducted before the COVID-19 epidemic, where combined high-flow venovenous ECMO and CytoSorb hemoadsorption therapy (CytoSorb filter connected to ECMO circuit) were applied in 13 patients with pneumogenic sepsis and ARDS. All patients survived in the CytoSorb group, while the 30-day mortality rate reached 57% in the control group. After CytoSorb therapy, a significant reduction in procalcitonin and CRP levels was immediately observed. CytoSorbents' purification technologies are based on biocompatible, highly porous polymer beads that can actively remove toxic substances from blood and other bodily fluids by pore capture and surface adsorption.

Vaccine development

A draft landscape of the candidate SARS-CoV-2 vaccines currently under development is regularly updated by WHO: https://www.who.int/blueprint/priority-diseases/key-action/novel-coronavirus-landscape-ncov.pdf?ua=1. According to other sources, within two months of the SAR-CoV-2 outbreak, at least 37 biopharmaceutical companies or academic sectors were reported to be in the race to develop a prophylactic vaccine by using several platforms including mRNA, DNA, adenoviral vector and recombinant protein (Prompetchara Asia Pac J All Imm 2020, see ***below***). However, the number of ongoing vaccine projects soon increased. As of April 28 2020, the dashboard of the London School of Hygiene and Tropical Medicine (https://vac-lshtm.shinyapps.io/ncov_vaccine_landscape/) described a total of 119 vaccine candidates.

Full-length S or S1 which contains receptor binding domain (RDB) might be considered as a good vaccine antigen as it could induce neutralizing antibodies preventing host cell attachment and infection. The S antigen has been included in different types of vaccines against infections by CoVs (Yu Micr Inf 2020, see ***below***). Conserved B cell and T cell epitopes between SARS-CoV and SARS-CoV-2 were also found in the viral nucleocapsid (N) protein (Ahmed Viruses 2020 see ***below***, Grifoni Cell Host & Microbe 2020, see ***below***).

Several candidate vaccines had completed Phase 1 clinical trials against SARS-CoV and MERS-CoV (https://www.who.int/blueprint/priority-diseases/key-action/prioritization-candidate-vaccines-ncov2019.pdf?ua=1. However, despite some level of sequence homology between SARS-CoV-2 and SARS-CoV, and to a lesser extent MERS-CoV, vaccine candidates developed against SARS-CoV and MERS-CoV are not expected to generate adequate levels of cross-reactive antibodies. Current efforts are thus focused on engineering and advancing vaccines that include antigens from the SARS-CoV-2 strain.

Lu (Emerg Microbes Inf 2020, see ***below***) described both the reasons why a COVID-19 vaccine is needed, and the challenges to be faced. Likewise, Amanat and Krammer gave their perspective on the development of SARS-CoV-2 vaccines and its challenges (Immunity 2020: https://els-jbs-prod-cdn.jbs.elsevierhealth.com/pb-assets/journals/research/immunity/SARS-CoV-2%20vaccines%20status%20report-1584537656897.pdf).

RNA vaccines

Stermirna Therapeutics Co., Ltd. and Shanghai East Hospital of Tongji University announced a project for the co-development of an mRNA vaccine targeting COVID-19 (http://www.xinhuanet.com/english/2020-01/28/c_138739378.htm). According to sources with the Chinese CDC, preclinical evaluation of this vaccine candidate in a mouse model is ongoing (http://www.xinhuanet.com/english/2020-02/10/c_138771569.htm).

Moderna, Inc. and the Coalition for Epidemic Preparedness Innovations (CEPI) announced a new collaboration to develop an mRNA vaccine against COVID-19 (https://investors.modernatx.com/news-releases/news-release-details/moderna-announces-funding-award-cepi-accelerate-development). Under the terms of the agreement, Moderna will manufacture an mRNA vaccine, which will be funded by CEPI. The Vaccine Research Center (VRC) of the National Institute of Allergy and Infectious Diseases (NIAID) collaborated with Moderna to design the vaccine. Moderna announced the initiation of the phase 1 trial of the mRNA-1273 vaccine on March 16 (https://investors.modernatx.com/news-releases/news-release-details/moderna-announces-first-participant-dosed-nih-led-phase-1-study). Information on this phase 1 clinical trial has been posted on the clinicaltrials.gov website (Safety and Immunogenicity Study of 2019-nCov Vaccine (mRNA-1273) to Treat Novel Coronavirus - Full Text View - ClinicalTrials.gov). The vaccine candidate mRNA-1273 consists of lipid nanoparticles packaged with nucleoside-modified mRNA that encodes a prefusion-stabilized form of the SARS-CoV-2 S protein. Three dose levels of mRNA-1273 (25, 100, 250 µg) are administered on a two-dose vaccination schedule, given 28 days apart. A total of 45 healthy adults will be enrolled in the study. Participants will be followed through 12 months after the second vaccination. The primary objective is to evaluate the safety and reactogenicity of a two-dose vaccination schedule of mRNA-1273. The secondary objective is to evaluate the immunogenicity to the SARS-CoV-2 S protein.

Curevac and CEPI also announced a collaboration to develop a vaccine against COVID-19 based on CureVac's technology and mRNA platform (https://www.curevac.com/news/curevac-and-cepi-extend-their-cooperation-to-develop-a-vaccine-against-coronavirus-ncov-2019#). Recently, CureVac announced that their mRNA platform using lipid nanoparticles in phase I study for the prevention of rabies was capable of providing protective virus-neutralizing antibody titers after two vaccination with dose of 1µg mRNA vaccine (https://www.curevac.com/news/curevac-announces-positive-results-in-low-dose-1-%C2%B5g-rabies-vaccine-clinical-phase-1-study).

eTheRNA immunotherapies announced that an international consortium is formed to develop an intranasal mRNA Vaccine for high risk populations of COVID-19 (https://www.ptcommunity.com/wire/etherna-launches-international-consortium-and-starts-development-cross-strain-protective-cov-2). The vaccine candidate aims to deliver mRNA encoding conserved epitopes of SARS-CoV-2 together with TriMix mRNA (mRNA based adjuvant) at the mucosal site in order to mount (memory) T cell responses.

BioNTech and **Pfizer** announced to collaborate on the development and distribution of a potential mRNA-based coronavirus vaccine aimed at preventing COVID-19 infection (https://investors.biontech.de/news-releases/news-release-details/pfizer-and-biontech-co-develop-potential-covid-19-vaccine). The vaccine candidate BNT162 builds on a joined programme initiated by BioNTech and Pfizer in 2018 for the development of an influenza mRNA vaccine. According to company communication on April 22, regulatory approval has been obtained from German authorities to commence the first clinical trial of the vaccine candidate. BioNTech also initiated an alliance with **Fosun Pharma** to conduct clinical trials in China with BioNTech's mRNA vaccine candidate BNT162.

Translate Bio also announced a collaboration with Sanofi Pasteur on a new mRNA COVID-19 vaccine (https://investors.translate.bio/news-releases/news-release-details/sanofi-pasteur-and-translate-bio-collaborate-develop-novel-mrna).

DNA vaccines

Inovio Pharmaceuticals, Inc. announced that it is developing INO-4800, a vaccine against COVID-19 based on the company's DNA platform, through Phase 1 human testing in the U.S. with the support of CEPI (http://ir.inovio.com/news-and-media/news/press-release-details/2020/Inovio-Collaborating-With-Beijing-Advaccine-To-Advance-INO-4800-Vaccine-Against-New-Coronavirus-In-China/default.aspx). The Phase 1 study of INO-4800, reported to have started on April 3rd, is enrolling 40 healthy adult volunteers who will receive 1 or 2 injections per visit of INO-4800 administered intradermally followed by electroporation using CELLECTRA® 2000 device, on day 0 and week 4 (https://clinicaltrials.gov/ct2/show/NCT04336410).

The company also announced that it is collaborating with Beijing Advaccine Biotechnology Co. to advance the vaccine candidate development in China. The goal of this collaboration is to leverage Advaccine's expertise to run a Phase 1 trial in China in parallel with Inovio's clinical development efforts in the U.S. Inovio and Advaccine will also work together to attract additional grant funding and further collaborations with larger vaccine companies in China to increase the speed of future testing of INO-4800.

Interestingly, INO-4700 (GLS-5300), Inovio's MERS-CoV vaccine, has already undergone Phase 1 clinical testing: the vaccine candidate appeared well-tolerated; it induced antibody responses in 94% of subjects after 3 injections; neutralizing antibodies were detected in 50% of participants, and T cell responses in 78% of study participants (Modjarrad Lancet Inf Dis 2019, see ***below***). Immune responses were dose-independent, and durable through 1 year of follow-up.

Subunit vaccines

Virus-like particles (nanoparticles)

On March 12 2020, Medicago announced the successful production of Virus-Like Particle (VLPs) of SARS-CoV-2 (https://www.medicago.com/en/covid-19-programs/). Preclinical studies were to be initiated in a very short timeframe.

Novavax is assessing nanoparticle vaccine candidates in animal models prior to identifying an optimal candidate for human testing, which is expected to begin in a few weeks (http://ir.novavax.com/news-releases/news-release-details/novavax-advances-development-novel-covid-19-vaccine). The company previously used its technology to develop vaccine candidates against SARS-CoV and MERS-CoV (see for instance, Coleman Vaccine 2014, see ***below***). Purified full-length MERS and SARS S proteins formed ~25 nm diameter particles consisting of multiple S protein molecules. The antigens were combined with Matrix M1 adjuvant and evaluated in mice.

Fusion protein-based approach

Viral fusion proteins undergo structural rearrangements from a metastable pre-fusion conformation to a highly stable post-fusion conformation (https://www.pharmalicensing.com/detail.php?uid=66499). Traditional approaches to recombinant expression of these proteins typically result in premature triggering and a conformational shift to the structurally more stable post-fusion form. The "molecular clamp" approach developed by the University of Queensland, Australia, uses a polypeptide moiety and has been shown to display increased stability over alternate stabilizing trimerization domains (https://patentscope.wipo.int/search/en/detail.jsf?docId=WO2018176103). This technique has already been used to produce chimeric polypeptides that mimic the pre-fusion conformations of HIV, respiratory syncytial virus, influenza, measles and Ebola viruses. The University of Queensland has been requested to use this technology to develop a vaccine candidate against COVID-19 (https://www.uq.edu.au/news/article/2020/01/race-develop-coronavirus-vaccine).

Adjuvanted vaccines

CEPI and Glaxo Smith Kline (GSK) announced a collaboration to develop a vaccine against COVID-19, which will leverage GSK's pandemic vaccine adjuvant technology (https://www.gsk.com/en-gb/media/press-releases/cepi-and-gsk-announce-collaboration-to-strengthen-the-global-effort-to-develop-a-vaccine-for-the-COVID-19-virus/). The adjuvant is designed to reduce the amount of antigen needed per patient and thereby to help stretch vaccine supplies. As part of the arrangement, an agreement between GSK and the University of Queensland will support early stage research on the molecular clamp vaccine. In a subsequent announcement, the University of Queensland reported they had created the first vaccine candidate in the laboratory and were moving into further development before formal pre-clinical testing (https://www.uq.edu.au/news/article/2020/02/significant-step%E2%80%99-covid-19-vaccine-quest).

In addition, the U.S. Department of Health and Human Services and Sanofi Pasteur announced a collaboration targeting the development of a COVID-19 vaccine candidate (https://www.hhs.gov/about/news/2020/02/18/hhs-engages-sanofis-recombinant-technology-for-2019-novel-coronavirus-vaccine.html; https://www.sanofi.com/-/media/Project/One-Sanofi-Web/Websites/Global/Sanofi-COM/Home/media-room/press-releases/2020/2020-02-18-16-00-00-1986380-en.pdf). The candidate will be based on proteins found on the surface of the virus and be produced by Sanofi Pasteur's (formerly Protein Sciences) baculovirus expression platform, which was initially developed to manufacture large quantities of pandemic influenza vaccines. According to Sanofi's press release, the vaccine candidate will be formulated. Even though not clearly stated in the announcement, it can be expected that an adjuvant will be used.

Another adjuvanted vaccine candidate is based on the S-trimer subunit vaccine candidate of Clover Biopharmaceuticals Inc. A research collaboration with GSK targeting evaluation of this candidate with GSK pandemic adjuvant system has indeed been announced (https://www.gsk.com/en-gb/media/press-releases/clover-and-gsk-announce-research-collaboration-to-evaluate-coronavirus-covid-19-vaccine-candidate-with-pandemic-adjuvant-system/).

Vectored vaccines

Adenovirus vectors

The **Ad5-nCoV** vaccine of CanSino Biologics is a replication-defective adenovirus type 5 vector expressing SARS-CoV-2 S protein. According to company communication, results from preclinical animal studies of Ad5-nCoV have shown that the vaccine candidate can induce strong immune response in animal models, and preclinical animal safety studies demonstrated a good safety profile (http://www.cansinotech.com/homes/article/show/56/153.html). According to media reports, the Phase 1 Clinical Trial has been initiated (https://www.thestar.com.my/news/regional/2020/03/22/china-embarks-on-clinical-trial-for-virus-vaccine). This trial is a single-centre, open and dose-escalation phase I trial, testing safety and tolerance of Ad5-nCoV in healthy adults, ages 18 to 60 years. The low-, middle- and high-dosage groups will each see 36 patients, who receive 5e10vp, 1e11vp and 1e11vp of Ad5-nCoV, respectively (http://www.chictr.org.cn/showprojen.aspx?proj=51154).

According to company communication, Altimmune develops a single-dose intranasal COVID-19 vaccine candidate, based on the technology used for their influenza vaccine candidate, NasoVAX, which is known to induce mucosal immunity as well as cell and IgG responses (https://ir.altimmune.com/static-files/f9e406df-9cc0-4fb7-9d9c-52d780679780). The candidate is a replication-deficient adenovirus 5 vector expressing SARS-CoV-2 S protein.

Johnson & Johnson also announced that it has initiated efforts to develop a vaccine candidate against COVID-19 (https://www.jnj.com/johnson-johnson-launches-multi-pronged-response-to-coronavirus-global-public-health-threat). The vaccine program will leverage Janssen's AdVac® and PER.C6® technologies that provide the ability to rapidly upscale production of the optimal vaccine candidate. These are the same technologies that were used in the development and manufacturing of Janssen's investigational Ebola adenovirus type 26 vector vaccine, which is

currently deployed in the Democratic Republic of the Congo and Rwanda. They were also used to construct the Company's Zika, respiratory syncytial virus and HIV vaccine candidates.

The Jenner Institute develops a ChAdOx1 nCoV-19 candidate, a vaccine based on the non-replicating chimpanzee adenovirus platform, previously used for a vaccine against MERS tested in phase 1 trials in UK and KSA (http://www.ox.ac.uk/news/2020-02-07-oxford-team-begin-novel-coronavirus-vaccine-research#). The vaccine seed stock has been produced at the University's Clinical Biomanufacturing Facility. A partnership with Advent in Italy allowed for the manufacturing of clinical batches.

Modified Vaccinia Ankara vector

GeoVax Labs, Inc., together with BravoVax, a vaccine developer in Wuhan, China, today announced the signing of a Letter of Intent to jointly develop a vaccine against COVID-19. Under the collaboration, GeoVax will use its MVA-VLP vaccine platform and expertise to design and construct the vaccine candidate using genetic sequences from the ongoing coronavirus outbreak. BravoVax will provide further development, including testing and manufacturing support, as well as direct interactions with Chinese public health and regulatory authorities. (https://www.geovax.com/news/geovax-and-bravovax-wuhan-china-to-collaborate-on-development-of-coronavirus-vaccine).

Other vectors

Tonix Pharmaceuticals announced a strategic collaboration with Southern Research to support the development of a vaccine, TNX-1800*, which is a live modified horsepox virus vaccine for percutaneous administration, to protect against COVID-19 (https://www.tonixpharma.com/news-events/press-releases/detail/1191/tonix-pharmaceuticals-announces-research-collaboration-with).

Inactivated vaccines

Sinovac Biotech used a similar strategy as selected for a SARS vaccine tested in a clinical trial 16 years ago (Cohen Science 2020, see ***below***). The SARS-CoV-2 vaccine is made by chemically inactivating whole virus particles and combination to Alum adjuvant. Of note, the WHO draft landscape of COVID-19 candidate vaccines (dated March 20) inaccurately described Sinovac's inactivation process as using formaldehyde. The company does chemically inactivate the virus, but does not want to disclose specifics.

Live-attenuated vaccines

Codagenix announced a collaboration with the Serum Institute of India to rapidly co-develop a live-attenuated vaccine against COVID-19 (https://www.prnewswire.com/news-releases/codagenix-and-serum-institute-of-india-initiate-co-development-of-a-scalable-live-attenuated-vaccine-against-the-2019-novel-coronavirus-covid-19-301004654.html). Codagenix uses viral deoptimization to synthesize "rationally designed," live-attenuated vaccines.

Non-vaccine approaches to better host resistance

Host resistance to viral infections can be increased in multiple ways. While there has been no report to date of such studies in the context of COVID-19, there is evidence available to support further investigations in this area.

Traditional Chinese Medicine

In China, the use of Traditional Chinese Medicine (TCM) to prevent epidemics of infectious diseases was traced back to ancient Chinese practice cited in Huangdi's Internal Classic (Huang Di Nei Jing), which was written about 2000 years ago (Luo Chin J Integr Med 2020, see ***below***). It suggested two aspects which should be employed to prevent the spread of epidemics. One was to maintain and improve the healthy qi in the body by taking preventive medicine (Xiaojin dan, the first recommended formula of TCM to prevent pestilence), healthy diet care, exercise and so on, so as to resist the invasion of external pathogen, and the other was to avoid the source of infection. These two principles

of epidemic disease prevention have been followed by TCM practitioners until now. In 2003, TCM approaches were used to prevent and treat SARS, and in 2009, during the influenza A(H1N1) pandemic, the National Administration of TCM of China issued a TCM prevention program, which included four Chinese herbal formulae for adults of different body constitutions and one for children. A literature review identified three studies using TCM for prevention of SARS and four studies for H1N1 influenza. None of the participants who took Chinese medicine contracted SARS in the three studies. The infection rate of H1N1 influenza in the TCM group was significantly lower than non-TCM group (RR 0.36, 95% CI 0.24-0.52; n=4). For prevention of COVID-19, 23 provinces in China issued TCM programs. The main principles of TCM use were to tonify qi to protect from external pathogens, disperse wind and discharge heat, and resolve dampness. The most frequently used herbs included *Astragali* (Huangqi), *Glycyrrhizae* (Gancao), *Saposhnikoviae* (Fangfeng), *Atractylodis Macrocephalae* (Baizhu), *Lonicerae Japonicae* (Jinyinhua), and *Forsythiae* (Lianqiao).

Psychoneuroimmunity aspects

A view point by Kim (Brain Behav Imm 2020, see ***below***) provided a reminder of the impact of a healthy lifestyle, regular exercise, balanced nutrition, quality sleep and a strong connection with people on resistance to infections. Although the psychological impact of COVID-19 remains unclear, infected patients may experience anxiety, depression, guilt, stigma, and anger. Such emotional issues may reduce immunity and compromise recovery. Current prevention efforts are largely focused on social distancing. The authors suggested that all forms of psychological support should be routinely implemented not only for psychological resilience, but also to enhance immunity against COVID-19.

Manipulating the commensal microbiota

A plethora of evidence suggests that the commensal microbiota regulates and is in turn regulated by invading viruses through diverse mechanisms, thereby having stimulatory or suppressive roles in viral infections (reviewed by Li Front Imm 2019, see below). Such knowledge could help design alternative approaches to the control of a number of viral infections, including COVID-19. A trial investigating the underlying mechanism of development of lower respiratory tract infection (LRTI) after viral infection showed for instance that patients with a higher abundance of butyrate-producing bacteria in their faecal samples had a 5-fold lower possibility of developing viral LRTI. Considering that butyrate-producing bacteria are favoured by a diet rich in fibers, similar studies on COVID-19 appear useful to undertake.

A particular strain of *Streptococcus salivarius*, known as K12, has been clinically demonstrated to help create a stable upper respiratory tract microbiota capable of protecting the host from pathogenic bacteria, fungi and viruses (Di Pierro Minerva Med 2020, see ***below***). The proposed antiviral effect has been attributed to an adaptive immune response as revealed by detection of enhanced levels of IFN-γ in human saliva 10 hours after oral administration, with values at 24 hours between 22 and 139 pg/ml. IFN-γ release occurs without modifying either IL-1β or TNF-α levels, and substantially lowering IL-8 release, therefore occurring without evoking an inflammatory response. Moreover, ***Streptococcus salivarius* K12** is capable of suppressing bronchial inflammatory responses by inhibiting NF-κB pathways and other important human immune cell functions. Interestingly, the authors noted that a significant difference in the lung microbiota composition has previously been reported between patients with SARS-CoV-2 pneumonia and healthy subjects (Shen Clin Inf Dis 2020, see ***below***). Among 8 subjects with SARS-CoV-2 pneumonia, 6 had a pathogen-enriched microbiota, and the other two had a commensal-enriched microbiota.

Curcumin?

Curcumin is considered as the major active compound in the rhizome of turmeric (*Curcuma longa*). Curcumin has been used extensively in Ayurveda, Siddha medicine and traditional Chinese medicine for centuries, as it has been associated with a variety of therapeutic properties including antioxidant, analgesic, anti-inflammatory, antiseptic activity, and anti-carcinogenic activity (reviewed by Mathew J Funct Foods 2018). Curcumin's antiviral effects were observed against numerous viruses including parainfluenza virus type 3, vesicular stomatitis virus (VSV), herpes

simplex virus, and RSV. Curcumin also appeared as a potent inhibitor when tested for its *in vitro* activity against SARS-CoV on Vero E6 cells (Wen J Med Chem 2007).

Various clinical trials provided promising results suggesting a low toxicity of curcumin. However, many questions and challenges still exist. Curcumin has been reported as an unstable, reactive, non-bioavailable compound (Nelson J Med Chem. 2017), and the lack of placebo-controlled trials to support its efficacy in humans has been pointed out (Nelson ACS Med Chem Lett 2017). The distinction between turmeric (the plant), curcuminoids (contained in turmeric and in extracts of turmeric) and curcumin also needs to be highlighted. Curcuminoids, as typically available commercially, contain not only curcumin but three primary components and approximately 15% of oleoresins and essential oil (Nelson 2017b).

Vitamins

Shi (Cell Death Diff 2020, see ***below***) indicated that **vitamin B3** has a protective role on lung tissue damage, and suggested its use as soon as cough is observed.

Grant (Nutrients 2020, see ***below***) presented evidence that **vitamin D** supplementation could reduce the risk of COVID-19 infections and deaths. This evidence includes that the outbreak occurred in winter, a time when 25-hydroxyvitamin D (25(OH)D) concentrations are lowest; that the number of cases in the Southern Hemisphere near the end of summer are low; that vitamin D deficiency has been found to contribute to acute respiratory distress syndrome; and that case-fatality rates increase with age and with chronic disease comorbidity, both of which are associated with lower 25(OH)D concentration. A similar recommendation was made by McCartney (Ir Med J. 2020, see ***below***).

Vector control and disease control in animals

Available evidence on SARS-CoV-2 and previous experience with other coronavirus (MERS-CoV and SARS-CoV) and other respiratory viruses (e.g., avian influenza) suggest that there may be zoonotic transmission associated with SARS-CoV-2. The following recommendations were therefore issued by WHO (https://www.who.int/health-topics/coronavirus/who-recommendations-to-reduce-risk-of-transmission-of-emerging-pathogens-from-animals-to-humans-in-live-animal-markets).

As of to date, the recommendations remain very general, as the animal species that may be involved in such transmission remain unknown.

As a general precaution, general hygiene measures are recommended to anyone visiting live animal markets, wet markets or animal product markets. These include regular hand washing with soap and potable water after touching animals and animal products, avoiding touching eyes, nose or mouth with hands, and avoiding contact with sick animals or spoiled animal products. It is also recommended to avoid contact with other animals possibly living in the market (e.g., stray cats and dogs) and with potentially contaminated animal waste or fluids on the soil or structures of shops and market facilities. A last recommendation is to avoid consumption of raw or undercooked animal products.

People with underlying medical conditions are considered at higher risk of severe disease. Therefore, individuals with these underlying medical conditions are recommended to avoid contact with live animal markets, stray animals and wild animals, and should not eat animal raw meat.

Good personal hygiene is specifically recommended to slaughterhouse workers, veterinarians in charge of animal and food inspection in markets, market workers, and those handling live animals and animal products. Use of protective gowns, gloves, masks as well as frequent disinfection of equipment and working stations, is also recommended.

Social interventions

Psychological intervention for affected people

It has been claimed that the mental health needs of patients with confirmed COVID-19, patients with suspected infection, quarantined family members, and medical personnel have been poorly handled in China, and that the organisation and management models for psychological interventions must be improved (Duan Lancet Psych 2020, see). With disease progression, clinical symptoms become severe and psychological problems in infected patients change; therefore, psychological intervention measures should be targeted and adapted as appropriate. Studies have confirmed that individuals who have experienced public health emergencies still have varying degrees of stress disorders, even after the event is over, or they have been cured and discharged from hospital, indicating these individuals should not be ignored. It is recommended that interventions are based on a comprehensive assessment of risk factors leading to psychological issues, including poor mental health before a crisis, bereavement, injury to self or family members, life-threatening circumstances, panic, separation from family and low household income.

Brooks (Lancet 2020, see ***below***) reviewed the psychological impact of quarantine. Most reviewed studies reported negative psychological effects including post-traumatic stress symptoms, confusion, and anger. Stressors included longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma. In situations where quarantine is deemed necessary, the author recommended officials to quarantine individuals for no longer than required, provide clear rationale for quarantine and information about protocols, and ensure sufficient supplies are provided. Appeals to altruism by reminding the public about the benefits of quarantine to wider society are presented as favourable.

Social media and information to the general public

Using data collected during the 2015 Middle East Respiratory Syndrome coronavirus (MERS-CoV) outbreak in South Korea, a study reported by Oh (Health Comm 2020, see ***below***) explored the relationships among social media use, risk perception, and preventive behaviours by examining the mediating role of two self-relevant emotions: fear and anger. The findings demonstrate that social media use is positively related to both of these emotions, which are also positively related to the public's risk perception. The findings also indicate that social media use can significantly increase preventive behaviours via the two self-relevant emotions and the public's risk perception.

In China, the government strives to improve the public's awareness of prevention and intervention strategies by providing daily updates about surveillance and active cases on websites and social media (Bao Lancet 2020, see ***below***). Increasingly, psychologists and psychiatrists use the internet and social media (e.g., WeChat, Weibo, etc) to share strategies for dealing with psychological stress. For example, experts from Peking University Sixth Hospital made six suggestions for the public to cope with mental stress. These included assessing the accuracy of information disclosed, enhancing social support systems (e.g., families and friends), eliminating stigma associated with the epidemic, maintaining a normal life under safe conditions, and using the psychosocial service system, particularly telephone-based and internet-based counselling for health-care staff, patients, family members, and the public. Liu (Lancet Psych 2020, see ***below***) even reported that several artificial intelligence (AI) programmes have been put in use as interventions for psychological crises during the epidemic. For example, individuals at risk of suicide can be recognised by the AI programme Tree Holes Rescue,5 by monitoring and analysing messages posted on Weibo, and alerting designated volunteers to act accordingly.

Outside China, at the start of the epidemic, the emergence of misinformation and racism against patients and Chinese visitors has been reported (Shimizu Lancet 2020, see ***below***). Excess demand for surgical masks among the general public also became a serious concern, as it lowered provision for medical facilities including emergency and critical care centres. It has been recommended that mass media take responsibility for providing correct information and creating comprehension among citizens. Effective communication may contribute to lessening the risk for

inappropriate behaviour, such as unnecessary visits to health-care facilities, as well as help eliminate fake news and discrimination against patients and Chinese visitors.

However, just as the coronavirus itself, misinformation has spread far and wide, drowning out credible sources of information (Mian BMC Med 2020, see ***below***). Over the last couple of months, posts from the WHO and the US CDC have cumulatively only achieved several hundred thousand engagements, considerably eclipsed by hoax and conspiracy theory sites, which have amassed over 52 million. This serves to emphasise the popularity of unverified sources of information.

Gonçalves-Sá (Nat Med. 2020, see ***below***) also highlighted the staggering amount of misinformation propagating online on the topic of COVID-19, including the most concerning conspiracy theory circulating online related to the factitious claim that the virus was engineered by the Chinese, with political or economic goals. The author noted that the decision to delete this misinformation publicly might reinforce conspiracy theories. As an alternative, it was suggested that social-media platforms could attempt to implement simple nudges: asking people whether they are sure they want to share something could activate their best judgment and reduce over-confidence; and introducing time delays on the publication of dubious information, while it is being checked, could slow the spreading process and eventually prevent its publication.

Mian (BMC Med 2020, see ***below***) noted that the disconnect between scientific consensus and members of the public has progressively worsened as society has become further divided in the political climate of today. Calisher (Lancet 2020, see) published a statement of solidarity to fight against COVID-19 and to promote scientific evidence and unity over misinformation and conjecture.

In February 2020, the Finnish Institute for Health and Welfare started collecting weekly qualitative data on COVID-19 risk perception. The process is based on thematic analysis of emails and social media messages from the public and identifies factors linked to appraisal of risk magnitude, which are developed into risk communication recommendations together with health and communication experts (Lohiniva EuroSurv 2020, see ***below***). The findings were related to five risk perception domains: catastrophic potential (e.g. emotional response, anticipation of growth of the epidemic), probability of dying (death perceived as likely), reasons for exposure (e.g. contact with infected persons, people coming from abroad or foreign nationals), the belief of being in control of the situation (a lack of the belief that a person can individually control the spread of the epidemic and instead a strong belief that authorities can do that), and trust towards authorities (distrust of information provided and actions taken by the authorities). This process helped develop context-specific risk communication messages.

Mental support for health care workers in hospitals

Several reports from China describe the importance of maintaining staff mental health when dealing with the epidemic. Various measures of psychological intervention were reported (see for instance Chen Lancet Psych 2020, see ***below***). First, the hospital provided a place for rest where staff could temporarily isolate themselves from their family. The hospital also guaranteed food and daily living supplies, and helped staff to video record their routines in the hospital to share with their families and alleviate family members' concerns. Second, in addition to disease knowledge and protective measures, pre-job training was arranged to address identification of and responses to psychological problems in patients with COVID-19, and hospital security staff were available to be sent to help deal with uncooperative patients. Third, the hospital developed detailed rules on the use and management of protective equipment to reduce worry. Fourth, leisure activities and training on how to relax were properly arranged to help staff reduce stress. Finally, psychological counsellors regularly visited the rest area to listen to difficulties or stories encountered by staff at work, and provide support accordingly.

Vulnerable groups

Elderly people

The outbreak of COVID-19 has raised great challenges for mental health services for older adults in the community in China. Yang (Lancet Psych 2020, see ***below***) noted that older adults have limited access to internet services and smart phones, and as such only a small fraction of older adults can benefit from such service provision. In addition, in most areas of China, clinically stable older adults with psychiatric disorders or their guardians usually need to visit psychiatric outpatient clinics monthly to obtain the maintenance medications. The mass quarantines and restrictions to public transport have inevitably become a major barrier to access maintenance treatments for this group.

Armitage (Lancet Public Health 2020, see ***below***) also predicted that self-isolation will disproportionately affect elderly individuals whose only social contact is out of the home, such as at day-care venues, community centres, and places of worship. Those who do not have close family or friends, and rely on the support of voluntary services or social care, could be placed at additional risk, along with those who are already lonely, isolated, or secluded.

International migrant workers

Regardless of their communities' self-reliance and resilience, Liem (Lancet Psych 2020, see ***below***) noted that addressing the health needs of international migrant workers should be made an urgent public health priority. Compared with other international migrants, migrant workers encounter more barriers in accessing health services in host countries. Under normal conditions, they have a high burden of common mental disorders (e.g., depression) and a lower quality of life than local populations. This situation could worsen during the COVID-19 epidemic due to the potential and fear of governmental-imposed quarantine and lost income. In the absence of reliable information in their own language, international migrant workers may not recognise the seriousness of the epidemic or receive accurate information on how to protect themselves from infection. However, most international migrant workers have smartphones, which can be a useful aid in providing informational and social support during the epidemic. For instance, WeChat (a Chinese social network platform) is used by international migrant workers in Hong Kong and Macau for sharing key health messages and official information to the community and providing one another with emotional support. It can, however, also spread inaccurate information and panic that could lead to IMWs delaying visits to health centres due to stigmatisation of those who are infected.

Homeless people

Tsai (Lancet Resp Med 2020, see ***below***) described various issues, which are unique to people experiencing homelessness, with regards to the COVID-19 epidemic. For instance, when cities impose a lockdown to prevent COVID-19 transmission, it is unclear whether shelter is provided for the large number of people experiencing homelessness, especially when considering that closures of shelters and other high-density communal settings (eg, drop-in centres and soup kitchens) are possible.

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