Lopinavir/Ritonavir and Other HIV Protease Inhibitors

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The replication of SARS-CoV-2 depends on the cleavage of polyproteins into an RNA-dependent RNA polymerase and a helicase.\(^1\) Two proteases are responsible for this cleavage: 3-chymotrypsin-like protease (3CLpro) and papain-like protease (PLpro).

Lopinavir/ritonavir and darunavir/cobicistat have been studied in patients with COVID-19. The clinical trials discussed below have not demonstrated a clinical benefit for protease inhibitors in patients with COVID-19.

**Recommendations**

- The COVID-19 Treatment Guidelines Panel (the Panel) **recommends against** the use of lopinavir/ritonavir and other HIV protease inhibitors for the treatment of COVID-19 in hospitalized patients (AI).
- The Panel **recommends against** the use of lopinavir/ritonavir and other HIV protease inhibitors for the treatment of COVID-19 in nonhospitalized patients (AIII).

**Rationale**

The pharmacodynamics of lopinavir/ritonavir raise concerns about whether it is possible to achieve drug concentrations that can inhibit the SARS-CoV-2 proteases.\(^2,3\) In addition, lopinavir/ritonavir did not show efficacy in two large randomized controlled trials in hospitalized patients with COVID-19.\(^4,5\)

There is currently a lack of data on the use of lopinavir/ritonavir in nonhospitalized patients with COVID-19. However, the pharmacodynamic concerns and the lack of evidence for a clinical benefit among hospitalized patients with COVID-19 undermine confidence that lopinavir/ritonavir has a clinical benefit at any stage of SARS-CoV-2 infection.

**Adverse Events**

The adverse events for lopinavir/ritonavir include:

- Nausea, vomiting, diarrhea (common)
- QTc prolongation
- Hepatotoxicity

**Drug-Drug Interactions**

Lopinavir/ritonavir is a potent inhibitor of cytochrome P450 3A. Coadministering lopinavir/ritonavir with medications that are metabolized by this enzyme may increase the concentrations of those medications, resulting in concentration-related toxicities. Please refer to the *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV* for a list of potential drug interactions.

**Summary of Clinical Data for COVID-19**

- The plasma drug concentrations achieved using typical doses of lopinavir/ritonavir are far below the levels that may be needed to inhibit SARS-CoV-2 replication.\(^3\)
- Lopinavir/ritonavir did not demonstrate a clinical benefit in hospitalized patients with COVID-19 during a large randomized trial in the United Kingdom.\(^4\)
• In a large international randomized trial, lopinavir/ritonavir did not reduce the mortality rate among hospitalized patients with COVID-19.⁵
• A moderately sized randomized trial (n = 199) failed to find a virologic or clinical benefit of lopinavir/ritonavir over standard of care.⁶
• Results from a small randomized controlled trial showed that darunavir/cobicistat was not effective for the treatment of COVID-19.⁷
• There are no data from clinical trials that support using other HIV protease inhibitors to treat COVID-19.
• Please see Clinical Data for COVID-19 below for more information.

Clinical Data for COVID-19
The information presented in this section may include data from preprints or articles that have not been peer reviewed. This section will be updated as new information becomes available. Please see ClinicalTrials.gov for more information on clinical trials that are evaluating lopinavir/ritonavir.

Lopinavir/Ritonavir in Hospitalized Patients With COVID-19: The RECOVERY Trial
The Randomised Evaluation of COVID-19 Therapy (RECOVERY) trial is an ongoing, open-label, randomized controlled trial with multiple arms, including a control arm; in one arm, participants received lopinavir/ritonavir. The trial was conducted across 176 hospitals in the United Kingdom and enrolled hospitalized patients with clinically suspected or laboratory-confirmed SARS-CoV-2 infection.⁴

Patients were randomized into several parallel treatment arms; this included randomization in a 2:1 ratio to receive either the usual standard of care only or the usual standard of care plus lopinavir 400 mg/ritonavir 100 mg orally every 12 hours for 10 days or until hospital discharge. Patients who had severe hepatic insufficiency or who were receiving medications that had potentially serious or life-threatening interactions with lopinavir/ritonavir were excluded from randomization into either of these arms. Mechanically ventilated patients were also underrepresented in this study because it was difficult to administer the oral tablet formulation of lopinavir/ritonavir to patients who were on mechanical ventilation. The primary outcome was all-cause mortality at Day 28 after randomization.

The lopinavir/ritonavir arm was discontinued on June 29, 2020, after the independent data monitoring committee concluded that the data showed no clinical benefit for lopinavir/ritonavir.

Patient Characteristics
• Of the 7,825 participants who were eligible to receive lopinavir/ritonavir, 1,616 were randomized to receive lopinavir/ritonavir and 3,424 were randomized to receive standard of care only. The remaining participants were randomized to other treatment arms in the study.
• In both the lopinavir/ritonavir arm and the standard of care arm, the mean age was 66 years; 44% of patients were aged ≥70 years.
• Test results for SARS-CoV-2 infection were positive for 88% of patients. The remaining 12% had a negative test result.
• Comorbidities were common; 57% of patients had at least one major comorbidity. Of those patients, 28% had diabetes mellitus, 26% had heart disease, and 24% had chronic lung disease.
• At randomization, 4% of patients were receiving invasive mechanical ventilation, 70% were receiving oxygen only (with or without noninvasive ventilation), and 26% were receiving neither.
• The percentages of patients who received azithromycin or another macrolide during the follow-up
period were similar in both arms (23% in the lopinavir/ritonavir arm vs. 25% in the standard of care arm). In addition, 10% of patients in both arms received dexamethasone.

Results

- There was no significant difference in the primary outcome of 28-day mortality between the two arms; 374 patients (23%) in the lopinavir/ritonavir arm and 767 patients (22%) in the standard of care arm had died by Day 28 (rate ratio 1.03; 95% CI, 0.91–1.17; \(P = 0.60\)).
- A similar 28-day mortality was reported for patients who received lopinavir/ritonavir in an analysis that was restricted to the 4,423 participants who had positive SARS-CoV-2 test results (rate ratio 1.05; 95% CI, 0.92–1.19; \(P = 0.49\)).
- Patients in the lopinavir/ritonavir arm and patients in the standard of care arm had similar median times to discharge (11 days in both arms) and similar probabilities of being discharged alive within 28 days (69% vs. 70%).
- Among participants who were not on invasive mechanical ventilation at baseline, patients who received lopinavir/ritonavir and those who received standard of care only had similar risks of progression to intubation or death.
- Results were consistent across subgroups defined by age, sex, ethnicity, or respiratory support at baseline.

Limitations

- The study was not blinded.
- No laboratory or virologic data were collected.

Interpretation

Lopinavir/ritonavir did not decrease 28-day all-cause mortality when compared to the usual standard of care in hospitalized persons with clinically suspected or laboratory-confirmed SARS-CoV-2 infection. Participants who received lopinavir/ritonavir and those who received standard of care only had similar median lengths of hospital stay. Among the patients who were not on invasive mechanical ventilation at the time of randomization, those who received lopinavir/ritonavir were as likely to require intubation or die during hospitalization as those who received standard of care.

**Lopinavir/Ritonavir in Hospitalized Patients with COVID-19: The Solidarity Trial**

The Solidarity trial was an open-label, randomized controlled trial that enrolled hospitalized patients with COVID-19 in 405 hospitals across 30 countries. The study included multiple arms; in one arm, participants received lopinavir/ritonavir. The control group for this arm included people who were randomized at the same site and time who could have received lopinavir/ritonavir but received standard of care instead. Lopinavir 400 mg/ritonavir 100 mg was administered orally twice daily for 14 days or until hospital discharge. Only the oral tablet formulation of lopinavir/ritonavir was available, which precluded administration to those on mechanical ventilation. The primary outcome was in-hospital mortality.

After the results of the RECOVERY trial prompted a review of the Solidarity data, the lopinavir/ritonavir arm ended enrollment on July 4, 2020. At that time, 1,411 patients had been randomized to receive lopinavir/ritonavir, and 1,380 patients received standard of care.

**Patient Characteristics**

- In both the lopinavir/ritonavir arm and the standard of care arm, 20% of the participants were aged \(\geq 70\) years and 37% were aged \(< 50\) years.
- Comorbidities were common. Diabetes mellitus was present in 24% of patients, heart disease in 21%, and chronic lung disease in 7%.
• At randomization, 8% of patients were receiving invasive mechanical ventilation or extracorporeal membrane oxygenation, 53% were receiving oxygen only (with or without noninvasive ventilation), and 39% were receiving neither.

• Similar percentages of patients received corticosteroids in the lopinavir/ritonavir arm and the standard of care arm (23% vs. 24%). Other nonstudy treatments were administered less often, and the use of these treatments was balanced between arms.

Results
• There was no significant difference in in-hospital mortality between the two arms; 148 patients (9.7%) in the lopinavir/ritonavir arm and 146 patients (10.3%) in the standard of care arm had died by Day 28 (rate ratio 1.00; 95% CI, 0.79–1.25; \( P = 0.97 \)).

• Progression to mechanical ventilation among those who were not ventilated at randomization occurred in 126 patients in the lopinavir/ritonavir arm and 121 patients in the standard of care arm.

• In-hospital mortality results appeared to be consistent across subgroups.

Limitations
• The study was not blinded.

• Those who were on mechanical ventilation were unable to receive lopinavir/ritonavir.

• The study includes no data on time to recovery.

Interpretation
Among hospitalized patients, lopinavir/ritonavir did not decrease in-hospital mortality or the number of patients who progressed to mechanical ventilation compared to standard of care.

**Lopinavir/Ritonavir Pharmacokinetics in Patients With COVID-19**

In a case series, eight patients with COVID-19 were treated with lopinavir 400 mg/ritonavir 100 mg orally twice daily and had plasma trough levels of lopinavir drawn and assayed by liquid chromatography-tandem mass spectrometry.³

Results
• The median plasma lopinavir concentration was 13.6 μg/mL.

• After correcting for protein binding, trough levels would need to be approximately 60-fold to 120-fold higher to achieve the in vitro half-maximal effective concentration (EC\(_{50}\)) for SARS-CoV-2.

Limitations
• Only the trough levels of lopinavir were quantified.

• The concentration of lopinavir required to effectively inhibit SARS-CoV-2 replication in vivo is currently unknown.

Interpretation
The plasma drug concentrations that were achieved using typical doses of lopinavir/ritonavir are far below the levels that may be needed to inhibit SARS-CoV-2 replication.

Other Reviewed Studies

The Panel has reviewed other clinical studies that evaluated the use of protease inhibitors for the treatment of COVID-19.⁶,⁸,⁹ These studies have limitations that make them less definitive and
informative than larger randomized clinical trials. The Panel’s summaries and interpretations of some of these studies are available in the archived versions of the Guidelines.

References


