Supplements

Last Updated: February 11, 2021

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**Rating of Recommendations:** A = Strong; B = Moderate; C = Optional

**Rating of Evidence:** I = One or more randomized trials without major limitations; IIa = Other randomized trials or subgroup analyses of randomized trials; IIb = Nonrandomized trials or observational cohort studies; III = Expert opinion

In addition to the antiviral medications and the immune-based therapies that are discussed elsewhere in the COVID-19 Treatment Guidelines, adjunctive therapies are frequently used in the prevention and/or treatment of COVID-19 or its complications. Some of these agents are being studied in clinical trials.

Some clinicians advocate for the use of vitamin and mineral supplements to treat respiratory viral infections. Ongoing studies are evaluating the use of vitamin and mineral supplements for both the treatment and prevention of SARS-CoV-2 infection.

The following sections describe the underlying rationale for using adjunctive therapies and summarize the existing clinical trial data. Other adjunctive therapies will be added as new evidence emerges.
Vitamin C

Vitamin C (ascorbic acid) is a water-soluble vitamin that is thought to have beneficial effects in patients with severe and critical illnesses. It is an antioxidant and free radical scavenger that has anti-inflammatory properties, influences cellular immunity and vascular integrity, and serves as a cofactor in the generation of endogenous catecholamines.\(^1,2\) Because humans may require more vitamin C in states of oxidative stress, vitamin C supplementation has been evaluated in numerous disease states, including serious infections and sepsis. Because SARS-CoV-2 infection may cause sepsis and acute respiratory distress syndrome (ARDS), the potential role of high doses of vitamin C in ameliorating inflammation and vascular injury in patients with COVID-19 is being studied.

**Recommendation for Non-Critically Ill Patients With COVID-19**

- There is insufficient evidence for the COVID-19 Treatment Guidelines Panel (the Panel) to recommend either for or against the use of vitamin C for the treatment of COVID-19 in non-critically ill patients.

**Rationale**

Because patients who are not critically ill with COVID-19 are less likely to experience oxidative stress or severe inflammation, the role of vitamin C in this setting is unknown.

**Clinical Data on Vitamin C in Outpatients With COVID-19**

**Oral Ascorbic Acid Versus Zinc Gluconate Versus Both Agents Versus Standard of Care**

In an open-label clinical trial that was conducted at two sites in the United States, outpatients with laboratory-confirmed SARS-CoV-2 infection were randomized to receive either 10 days of oral ascorbic acid 8,000 mg, zinc gluconate 50 mg, both agents, or standard of care.\(^3\) The primary end point was the number of days required to reach a 50% reduction in the patient’s symptom severity score. The study was stopped early by an operational and safety monitoring board due to futility after 40% of the planned 520 participants were enrolled (n = 214).

Patients who received standard of care achieved a 50% reduction in their symptom severity scores at a mean of 6.7 days (SD 4.4 days) compared with 5.5 days (SD 3.7 days) for the ascorbic acid arm, 5.9 days (SD 4.9 days) for the zinc gluconate arm, and 5.5 days (SD 3.4 days) for the arm that received both agents (overall \(P = 0.45\)). Nonserious adverse effects occurred more frequently in patients who received supplements than in those who did not; 39.5% of patients in the ascorbic acid arm, 18.5% in the zinc gluconate arm, and 32.1% in the arm that received both agents experienced nonserious adverse effects compared with 0% of patients in the standard of care arm (overall \(P < 0.001\)). The most common nonserious adverse effects in this study were gastrointestinal events.

The limitations of this study include the small sample size and the lack of a placebo control. In outpatients with COVID-19, treatment with high-dose zinc gluconate, ascorbic acid, or a combination of the two supplements did not significantly decrease the number of days required to reach a 50% reduction in a symptom severity score compared with standard of care.

**Recommendation for Critically Ill Patients With COVID-19**

- There is insufficient evidence for the Panel to recommend either for or against the use of vitamin C for the treatment of COVID-19 in critically ill patients.
Rationale

There are no controlled trials that have definitively demonstrated a clinical benefit for vitamin C in critically ill patients with COVID-19, and the available observational data are inconclusive. Studies of vitamin C regimens in sepsis patients and ARDS patients have reported variable efficacy and few safety concerns.

Clinical Data on Vitamin C in Critically Ill Patients

Intravenous Vitamin C Alone in Patients With COVID-19

A pilot clinical trial in China randomized 56 adults with COVID-19 in the intensive care unit to receive intravenous (IV) vitamin C 24 g per day or placebo for 7 days. The study was terminated early due to a reduction in the number of cases of COVID-19 in China. Overall, the study found no differences between the arms in mortality, the duration of mechanical ventilation, or the change in median sequential organ failure assessment (SOFA) scores. The study reported improvements in oxygenation (as measured by the ratio of arterial partial pressure of oxygen to fraction of inspired oxygen \(\text{PaO}_2/\text{FiO}_2\)) from baseline to Day 7 in the treatment arm that were statistically greater than those observed in the placebo arm (+20.0 vs. -51.9; \(P = 0.04\)).

Intravenous Vitamin C Alone in Patients Without COVID-19

A small, three-arm pilot study compared two regimens of IV vitamin C to placebo in 24 critically ill patients with sepsis. Over the 4-day study period, patients who received vitamin C 200 mg/kg per day and those who received vitamin C 50 mg/kg per day had lower SOFA scores and lower levels of proinflammatory markers than patients who received placebo.

In a randomized controlled trial in critically ill patients with sepsis-induced ARDS (\(n = 167\)), patients who received IV vitamin C 200 mg/kg per day for 4 days had SOFA scores and levels of inflammatory markers that were similar to those observed in patients who received placebo. However, 28-day mortality was lower in the treatment group (29.8% vs. 46.3%; \(P = 0.03\)), coinciding with more days alive and free of the hospital and the intensive care unit. A post hoc analysis of the study data reported a difference in median SOFA scores between the treatment group and placebo group at 96 hours; however, this difference was not present at baseline or 48 hours.

Intravenous Vitamin C Plus Thiamine With or Without Hydrocortisone in Critically Ill Patients Without COVID-19

Two small studies that used historic controls reported favorable clinical outcomes (i.e., reduced mortality, reduced risk of progression to organ failure, and improved radiographic findings) in patients with sepsis or severe pneumonia who received a combination of vitamin C, thiamine, and hydrocortisone. Subsequently, several randomized trials in which patients received vitamin C and thiamine (with or without hydrocortisone) to treat sepsis and septic shock showed that this combination conferred benefits for certain clinical parameters. However, no survival benefit was reported. Two trials observed reductions in organ dysfunction (as measured by change in SOFA score on Day 3) or the duration of shock without an effect on clinical outcomes. Three other trials, including a large trial of 501 sepsis patients, found no differences in any physiologic or outcome measures between the treatment and placebo groups.

See ClinicalTrials.gov for a list of clinical trials that are evaluating the use of vitamin C in patients with COVID-19.

Other Considerations

It is important to note that high circulating concentrations of vitamin C may affect the accuracy of point-of-care glucometers.


Vitamin D

Last Updated: April 21, 2021

**Recommendation**

- There is insufficient evidence to recommend either for or against the use of vitamin D for the prevention or treatment of COVID-19.

**Rationale**

Vitamin D is critical for bone and mineral metabolism. Because the vitamin D receptor is expressed on immune cells such as B cells, T cells, and antigen-presenting cells, and because these cells can synthesize the active vitamin D metabolite, vitamin D also has the potential to modulate innate and adaptive immune responses.¹

Vitamin D deficiency (defined as a serum concentration of 25-hydroxyvitamin D ≤20 ng/mL) is common in the United States, particularly among persons of Hispanic ethnicity and Black race. These groups are also overrepresented among cases of COVID-19 in the United States.² Vitamin D deficiency is also more common in older patients and patients with obesity and hypertension; these factors have been associated with worse outcomes in patients with COVID-19. In observational studies, low vitamin D levels have been associated with an increased risk of community-acquired pneumonia in older adults³ and children.⁴

Vitamin D supplements may increase the levels of T regulatory cells in healthy individuals and patients with autoimmune diseases; vitamin D supplements may also increase T regulatory cell activity.⁵ In a meta-analysis of randomized clinical trials, vitamin D supplementation was shown to protect against acute respiratory tract infection.⁶ However, in two double-blind, placebo-controlled, randomized clinical trials, administering high doses of vitamin D to critically ill patients with vitamin D deficiency (but not COVID-19) did not reduce the length of the hospital stay or the mortality rate when compared to placebo.⁷,⁸ High levels of vitamin D may cause hypercalcemia and nephrocalcinosis.⁹

The rationale for using vitamin D is based largely on immunomodulatory effects that could potentially protect against COVID-19 infection or decrease the severity of illness. Ongoing observational studies are evaluating the role of vitamin D in preventing and treating COVID-19. Some investigational trials on the use of vitamin D in people with COVID-19 are being planned or are already accruing participants. These trials will administer vitamin D alone or in combination with other agents to participants with and without vitamin D deficiency. The latest information on these clinical trials can be found on ClinicalTrials.gov.

**Clinical Data**

**Randomized Clinical Trial of Vitamin D Versus Placebo in Patients With Moderate to Severe COVID-19**

In a double-blind, placebo-controlled randomized trial that was conducted at two sites in Brazil, 240 hospitalized patients with moderate to severe COVID-19 received either a single dose of 200,000 international units of vitamin D₃ or placebo.¹⁰ Moderate to severe COVID-19 was defined as patients with a positive result on a SARS-CoV-2 polymerase chain reaction test (or compatible computed tomography scan findings) and a respiratory rate >24 breaths/min, oxygen saturation <93% on room air, or risk factors for complications. The primary outcome in this study was the length of the hospital stay.
The median length of stay was not significantly different between the vitamin D₃ arm (7.0 days [IQR 4.0–10.0 days]) and the placebo arm (7.0 days [IQR 5.0–13.0 days]; \( P = 0.59 \), log-rank test). No significant differences were observed between the arms in the percentages of patients who were admitted to the intensive care unit, who required mechanical ventilation, or who died during hospitalization.

It should be noted that this study had a small sample size and enrolled participants with a variety of comorbidities and concomitant medications. The time between symptom onset and randomization was relatively long, with patients randomized at a mean of 10.3 days after symptom onset. In this study, a single, high dose of vitamin D₃ did not significantly reduce the length of stay for hospitalized patients with COVID-19.

References

Zinc

Last Updated: April 21, 2021

Recommendations

• There is insufficient evidence for the COVID-19 Treatment Guidelines Panel (the Panel) to recommend either for or against the use of zinc for the treatment of COVID-19.

• The Panel recommends against using zinc supplementation above the recommended dietary allowance for the prevention of COVID-19, except in a clinical trial (BIII).

Rationale

Increased intracellular zinc concentrations efficiently impair replication in a number of RNA viruses. Zinc has been shown to enhance cytotoxicity and induce apoptosis when used in vitro with a zinc ionophore (e.g., chloroquine). Chloroquine has also been shown to enhance intracellular zinc uptake in vitro. The relationship between zinc and COVID-19, including how zinc deficiency affects the severity of COVID-19 and whether zinc supplements can improve clinical outcomes, is currently under investigation. Zinc levels are difficult to measure accurately, as zinc is distributed as a component of various proteins and nucleic acids.

Several clinical trials are currently investigating the use of zinc supplementation alone or in combination with hydroxychloroquine for the prevention and treatment of COVID-19 (see ClinicalTrials.gov for more information about ongoing studies). The recommended dietary allowance for elemental zinc is 11 mg daily for men and 8 mg for nonpregnant women. The doses used in registered clinical trials for patients with COVID-19 vary between studies, with a maximum dose of zinc sulfate 220 mg (50 mg of elemental zinc) twice daily. However, there is currently insufficient evidence to recommend either for or against the use of zinc for the treatment of COVID-19.

Long-term zinc supplementation can cause copper deficiency with subsequent reversible hematologic defects (i.e., anemia, leukopenia) and potentially irreversible neurologic manifestations (i.e., myelopathy, paresthesia, ataxia, spasticity). The use of zinc supplementation for durations as short as 10 months has been associated with copper deficiency. Oral zinc can decrease the absorption of medications that bind with polyvalent cations. Because zinc has not been shown to have a clinical benefit and may be harmful, the Panel recommends against using zinc supplementation above the recommended dietary allowance for the prevention of COVID-19, except in a clinical trial (BIII).

Clinical Data

Randomized Clinical Trial of Zinc Plus Hydroxychloroquine Versus Hydroxychloroquine Alone in Hospitalized Patients With COVID-19

In a randomized clinical trial that was conducted at three academic medical centers in Egypt, 191 patients with laboratory-confirmed SARS-CoV-2 infection were randomized to receive either zinc 220 mg twice daily plus hydroxychloroquine or hydroxychloroquine alone for a 5-day course. The primary endpoints were recovery within 28 days, the need for mechanical ventilation, and death. The two arms were matched for age and gender.

Results

• There were no significant differences between the two arms in the percentages of patients who recovered within 28 days (79.2% in the hydroxychloroquine plus zinc arm vs. 77.9% in the hydroxychloroquine only arm; \( P = 0.969 \)), the need for mechanical ventilation \( (P = 0.537) \), or...
overall mortality ($P = 0.986$).

- The only risk factors for mortality were age and the need for mechanical ventilation.

**Limitations**

- This study had a relatively small sample size.

**Interpretation**

A moderately sized randomized clinical trial failed to find a clinical benefit for the combination of zinc and hydroxychloroquine.

**Open-Label, Randomized Trial of Zinc Versus Ascorbic Acid Versus Zinc Plus Ascorbic Acid Versus Standard of Care in Outpatients With COVID-19**

In an open-label clinical trial that was conducted at two sites in the United States, outpatients with laboratory-confirmed SARS-CoV-2 infection were randomized to receive either 10 days of zinc gluconate 50 mg, ascorbic acid 8,000 mg, both agents, or standard of care. The primary end point was the number of days required to reach a 50% reduction in the patient’s symptom severity score. The study was stopped early by an operational and safety monitoring board due to futility after 40% of the planned 520 participants were enrolled ($n = 214$).^9

**Results**

- Participants who received standard of care achieved a 50% reduction in their symptom severity scores at a mean of 6.7 days (SD 4.4 days) compared with 5.5 days (SD 3.7 days) for the ascorbic acid arm, 5.9 days (SD 4.9 days) for the zinc gluconate arm, and 5.5 days (SD 3.4 days) for the arm that received both agents (overall $P = 0.45$).

- Nonserious adverse effects occurred more frequently in patients who received supplements than in those who did not; 39.5% of patients in the ascorbic acid arm, 18.5% in the zinc gluconate arm, and 32.1% in the arm that received both agents experienced nonserious adverse effects compared with 0% of patients in the standard of care arm (overall $P < 0.001$). The most common nonserious adverse effects in this study were gastrointestinal events.

**Limitations**

- The study had a small sample size.

- There was no placebo control.

**Interpretation**

In outpatients with COVID-19, treatment with high-dose zinc gluconate, ascorbic acid, or a combination of the two supplements did not significantly decrease the number of days required to reach a 50% reduction in a symptom severity score compared with standard of care.

**Observational Study of Zinc Supplementation in Hospitalized Patients**

A retrospective study enrolled 242 patients with polymerase chain reaction-confirmed SARS-CoV-2 infection who were admitted to Hoboken University Medical Center. One hundred and ninety-six patients (81.0%) received a total daily dose of zinc sulfate 440 mg (100 mg of elemental zinc); of those, 191 patients (97%) also received hydroxychloroquine. Among the 46 patients who did not receive zinc, 32 patients (70%) received hydroxychloroquine. The primary outcome was days from hospital admission to in-hospital mortality, and the primary analysis explored the causal association between zinc therapy and survival.\(^{10}\)

**Results**
• There were no significant differences in baseline characteristics between the arms. In the zinc arm, 73 patients (37.2%) died compared with 21 patients (45.7%) in the control arm. In the primary analysis, which used inverse probability weighting (IPW), the effect estimate of zinc therapy was an additional 0.84 days of survival (95% CI, -1.51 days to 3.20 days; \( P = 0.48 \)).

• In a multivariate Cox regression analysis with IPW, the use of zinc sulfate was not significantly associated with a change in the risk of in-hospital mortality (aHR 0.66; 95% CI, 0.41–1.07; \( P = 0.09 \)).

• Older age, male sex, and severe or critical COVID-19 were significantly associated with an increased risk of in-hospital mortality.

Limitations
• This is a retrospective study; patients were not randomized to receive zinc supplementation or to receive no zinc.

Interpretation
This single-center, retrospective study failed to find a mortality benefit in patients who received zinc supplementation.

Multicenter, Retrospective Cohort Study That Compared Hospitalized Patients Who Received Zinc Plus Hydroxychloroquine to Those Who Did Not
This study has not been peer reviewed.

This multicenter, retrospective cohort study of hospitalized adults with SARS-CoV-2 infection who were admitted to four New York City hospitals between March 10 and May 20, 2020, compared patients who received zinc plus hydroxychloroquine to those who received treatment that did not include this combination.\(^{11}\)

Results
• The records of 3,473 patients were reviewed.
• The median patient age was 64 years; 1,947 patients (56%) were male, and 522 patients (15%) were mechanically ventilated.
• Patients who received an interleukin-6 inhibitor or remdesivir were excluded from the analysis.
• A total of 1,006 patients (29%) received zinc plus hydroxychloroquine, and 2,467 patients (71%) received hydroxychloroquine without zinc.
• During the study, 545 patients (16%) died. In univariate analyses, mortality rates were significantly lower among patients who received zinc plus hydroxychloroquine than among those who did not (12% vs. 17%; \( P < 0.001 \)). Similarly, hospital discharge rates were significantly higher among patients who received zinc plus hydroxychloroquine than among those who did not (72% vs. 67%; \( P < 0.001 \)).
• In a Cox regression analysis that adjusted for confounders, treatment with zinc plus hydroxychloroquine was associated with a significantly reduced risk of in-hospital death (aHR 0.76; 95% CI, 0.60–0.96; \( P = 0.023 \)). Treatment with zinc alone (n = 1,097) did not affect mortality (aHR 1.14; 95% CI, 0.89–1.44; \( P = 0.296 \)), and treatment with hydroxychloroquine alone (n = 2,299) appeared to be harmful (aHR 1.60; 95% CI, 1.22–2.11; \( P = 0.001 \)).
• There were no significant interactions between zinc plus hydroxychloroquine and other COVID-19-specific medications.
Limitations

- This is a retrospective review; patients were not randomized to receive zinc plus hydroxychloroquine or to receive other treatments.
- The authors do not have data on whether patients were taking zinc and/or hydroxychloroquine prior to study admission.
- The arms were not balanced; recipients of zinc plus hydroxychloroquine were more likely to be male, Black, or to have a higher body mass index and diabetes. Patients who received zinc plus hydroxychloroquine were also treated more often with corticosteroids and azithromycin and less often with lopinavir/ritonavir than those who did not receive this drug combination.

Interpretation

In this preprint, the use of zinc plus hydroxychloroquine was associated with decreased rates of in-hospital mortality, but neither zinc alone nor hydroxychloroquine alone reduced mortality. Treatment with hydroxychloroquine alone appeared to be harmful.

References