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. In addition, 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 ($n = 214$).

**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.
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


