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Combinations of drugs might increase the Survival chances of COVID-19 patients: Literature review till date

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Introduction:

SARS-COV-2 explores every possible vulnerability in human body and uses it against the host. To treat this SARS-COV-2 induced COVID-19, we should target the multiple factors virus is targeting and use the drugs in a strategical way. This approach can save the patients from severe state of illness and damage associated with the disease.

1. SARS-COV-2 induces delayed humoral responses and accelerated innate immune response mediated damages:

COVID-19 has been associated with hyper inflammation [10-18] and delayed humoral immune responses [19,20,21,22,23,24]. Most of the complications with COVID-19 patients have been associated with early hypoxia, ARDS, pneumonia [60,77,35-39] and Acute Lung Injury [30-34]. Viral load has been found to be associated directly with incidence of lung injury/epithelial injury or remote organ injury in COVID-19 patients [25-30].

2. Delayed Humoral Responses in Severe COVID-19 Patients:

Hasan et.al though their studies have attributed the severe form of Covid-19 to a dysfunctional innate immune response, such as a delayed and/or deficient type I/III interferon response, coupled with an exaggerated and/or a dysfunctional adaptive immunity [21]. Differences in T-cell (including CD4+ T-cells, CD8+ T-cells, T follicular helper cells, $\gamma\delta$ -T-cells, and regulatory T-cells) and B-cell (transitional cells, double-negative 2 cells, antibody-secreting cells) responses have been identified in patients with severe disease compared to mild cases [21]. Moreover, differences in the kinetic/titer of neutralizing antibody responses have been described in severe COVID-19 disease, which may be confounded by antibody-dependent enhancements [21].

Lucas et.al observed a correlation between anti-spike (S) immunoglobulin G (IgG) levels, length of hospitalization and clinical parameters associated with worse clinical progression [19]. Although high anti-S IgG levels correlated with worse disease severity, such correlation was reported to be time dependent [19]. Lucas et.al reported that deceased patients did not have higher overall humoral response than discharged patients [19]. However, they mounted a robust, yet delayed, response, measured by anti-S, anti-receptor-binding domain IgG and neutralizing antibody (NAb) levels compared to survivors [19]. Delayed seroconversion kinetics correlated with impaired viral control in deceased patients [19]. Finally, although sera from 85% of patients displayed some neutralization capacity during their disease course, NAb generation before 14 day of disease onset emerged as a key factor for recovery [19]. These data indicate that COVID-19 mortality does not correlate with the cross-sectional antiviral antibody levels per se but, rather, with the delayed kinetics of NAb production [19].

Thalia et.al studied 55 Covid-19 patients (59.7±16.2 years, 63.6% male), of which 28 (50.9%) died [23]. Thalia et.al observed the IgA and IgG positivity (IgA+ and IgG+) in 90.9% and 80% of total patients,

respectively [23]. The highest IgA+ frequency was observed at weeks 2 and 3 and the highest IgG+ at weeks 3 and 4 [23]. It is important to note that patients who died presented lower IgA titers in the first two weeks however, a significant increase in IgA levels was observed in the subsequent weeks [32]. Thalia et al identified that significant correlations between Ct values and immunoglobulins levels, both IgA and IgG were correlated with Ct N2 in patients who died [23].

Thalia et.al though their study and results concluded that lower IgA titers in early Covid-19, which is associated with lower Ct values, may indicate patients at higher risk for death [23].

Fraser et.al reported that Peak serological responses for each Ig isotype occurred on different ICU days (IgM day 13 >IgA day 17 > IgG persistently increased), with the total Ig peaking at approximately ICU day 18 [24]. Fraser et.al found that COVID-19+ patients who died had earlier/similar peaks in IgA and total Ig in their ICU stay when compared with the patients who have survived [24]. Critically ill COVID-19 patients exhibit anti-SARS-CoV-2 serological responses, including those COVID-19 patients who ultimately died, suggesting that blunted serological responses did not contribute to mortality [24].

3. To Reduce early Viral Load as much as possible is the key to controlling SARS-COV-2 mediated damage:

Supportively, SARS-COV-2 Viral load has been associated directly with lung injury, endothelial damage and other organ injury in COVID-19 patients [25-30]. After Lung Injury or other systemic organ injury independent of Virus the situation can be treated as systemic inflammatory response syndrome (SIRS) which ultimately leads to Sepsis [441,472,473].

4. In order to observe better results in treatment, it's critical to slow down the viral growth because:

1. Virus promotes the recruitment of more Neutrophils and induces more damage to infected organs especially lungs. Virus mediated damage in AT-II lung cells induces collapse of alveolar chambers due to the lack of surfactant and associated surface tension. This leads to Hypoxia in patients.
2. More virus can bind to more LPS in systemic blood and lead to elevated inflammatory response in initial stage and elevated immunosuppressive response in the late phase of systemic Injury inflammatory response mediated Sepsis.
3. More viral burden leads to increased Cellular death and subsequent release of elevated HMGB-1 and other DAMPs.

Conclusively, Delayed Viral entry and reduced subsequent viral load can reduce the immune system mediated damage and might give sufficient amount of time for humoral responses, debris clearance and might delay the possibility of Injury and subsequent onset of Inflammation induced Sepsis.

In this study we will briefly understand the benefits of different drugs and their combinations reported by different authors though their analysis, trials or experiments which were reported to be useful in COVID-19 treatment.

Overview of the studies that found different combinations of drugs to be effective in COVID-19 till date:

1. Povidone-Iodine (PVP-I) Solution Gargles and Nasal spray/swabs:

1. Recent evidence has confirmed that 0.5% povidone iodine (PVP-I) mouthrinse/gargle for 30 s can reduce SARS-CoV-2 virus infectivity to below detectable levels [148,149,151,152,153,154].
2. Hassandarvish et.al showed that 1% PVP-I achieved > 5 logs 10 reductions in the SARS CoV-2 virus titre at 15, 30 and 60 seconds [150].
3. PVP-I can even interrupt SARS-CoV-2 attachment to oral and nasopharyngeal tissues and lower the viral particles in the saliva and respiratory droplets [148].
4. PVP-I kills SARS-COV-2 at surface, reduces viral burden and prevents SARS-COV-2 early entry into the systemic blood through damaged endothelial cells in Oral and Nasal compartments.
5. PVP-I can kill fungal and bacterial infection [156,157].
6. Periodontitis and associated bacterial can drive inflammation in COVID-19 patients [96,97,112].
7. Periodontitis and associated bacterial LPS can bind to SARS-COV-2 [834] and induces elevated pro-inflammatory immune responses. PVP-I can kill this bacteria [158,159,160].
8. Prevents dangerous Secondary Infections through mouth and Nose during Immuno compromised condition established during the usage of dexamethasone, a immunosuppressant. PVP-I Gargle and spray might provide protection against Mucormycosis and secondary bacterial infections.
9. **Mohamed et.al conducted a pilot trial and reported that a 3 times/day gargling usage of 1% povidone-iodine (PVP-I) in five COVID-19 confirmed Asymptomatic Stage 1 patients including two comorbid patients, when monitored on day 4,6 and 12 showed a higher viral clearance from as early as day 4 [155].**

2. Nebulized-NAC (N-Acetyl- Cysteine) and TMPRSS-2 Inhibitor:

1. Li et.al concluded that Camostat and nafamostat inhibits SARS-CoV-2 infection in well differentiated human airway epithelial cells [140].
2. Li et.al observed that the effectiveness of nafamostat administration through intranasal channel increased as the time interval between nafamostat delivery and viral inoculation decreased [140]. Although intranasal nafamostat effectiveness in humans is not yet known fully [140].
3. **Mccord et.al reported that interaction of SARS-COV-2 spike protein with ACE-2 was blocked by clinically proven protease inhibitors of the TMPRSS2, Camostat mesylate [145,146,137] and Nafamostat mesylate [137].**
4. Nebulized NAC Disrupts disulfides at the surface of ACE-2 receptor and reduces SARS-COV-2 confirmational change mediated host cellular entry [133].
5. **Akhter et.al through their experiments reported that Acetylcysteine was able to reduce only 58% of the disulfide linkages [133].**
6. Sagar et.al reported that Bromelain reduced the expression of TMPRSS2 in Calu-3 and ACE-2 negative normal bronchial epithelial (BEAS-2B) and lung adenocarcinoma (A549) cells [136].
7. **Akhter et .al showed that treatment with Bromelain and Acetylcysteine alone each independently did not show any viral inhibition whereas BromAc a combination of both Bromelain and Acetylcysteine (NAC) displayed complete SARS-COV-2 virus inactivation in a concentration dependent manner [133].**

8. Manček et.al found that NAC alone did not inhibit cell fusion but its derivative NACA [138], with more potent antioxidant properties, strongly inhibited the formation of syncytia[135]. This is in agreement with the other authors results in showing that using NAC alone cannot inhibit viral entry but can help reducing disulfides [133].
9. **Manček et.al proposed that NACA, L-ascorbic acid, and JTT-705 alone efficiently inhibited the interaction between SARS-COV-2 spike and ACE2 binding independent of each other , implying that this group of compounds each alone can affect the direct interaction between SARS-COV-2 spike and ACE2 when observed in lung-derived A549 cells [135].**
10. Several other studies have also opined that Disulfide confirmation perturbations at ACE-2 surface can inhibit SARS-COV-2 cellular entry [130,1392,124].
11. **ACE-2 expression is upregulated along with TLR-4 during pro-inflammatory medium in lungs of COVID-19 patients [2029,1394].**
12. **Nebulized NAC deceases ACE-2 expression at the targeted organ i.e airway epithelial cells and lungs [125,126].**
13. Nebulized NAC reduces ROS directly at the target site and reduces cell death and HMGB-1 mediated subsequent inflammatory responses .
14. Acts as an Anti-oxidant directly at lung epithelial cells.

3. Intranasal / IV-Tempol:

Manček et.al found that NAC alone did not inhibit cell fusion but its derivative NACA [138] which has more potent antioxidant properties, strongly inhibited the formation of syncytia [135]. Tempol a super antioxidant might be as well a good choice [5].

Tempol is an powerful antioxidant [2,4,58,73]. Tempol relieves lung injury in a rat model of chronic intermittent hypoxia via suppression of inflammation and oxidative stress [3]. Tempol is protective against Hypoxia-induced Oxidative Stress and Apoptosis [1]. Maio et.al reported that Tempol can inhibit the viral replication by potentially inhibiting the RdRp [7]. Kavita et.al through their experiments concluded that Tempol as a novel antioxidant might inhibit both activated T cell and antigen presenting cell derived cytokines production in-vitro from COVID-19 patients [6].

Tempol in COVID-19:

Peter et.al reported that early administration of Intranasal Tempol treatment in a single COVID-19 patients reduced nasal congestion by day 4-5 and was found to be asymptomatic by day 8 [76]. Although it's a single case report taken into account that powerful antioxidant can inhibit viral entry and taken that Tempol inhibits viral replication of SARS-COV-2 and taken into account the SARS-COV-2 induced Oxidative stress and associated cell death, Intranasal/Nebulized Tempol administration along with standard care can increase the out come drastically [76].

4. NAC-IV (Intravenous NAC (N-Acetyl-Cysteine)):

1. Acts as anti-oxidant [127, 129].
2. NAC deceases ACE-2 expression [125,126].
3. NAC might upregulate TLR-7 expression [131].
4. Reduces confirmational change for SARS-COV-2 at systemic organ level.
5. **Suppresses Pro-inflammatory Cytokines in Severe COVID-19 patients when administered continuously [9].**
6. **IV-NAC provides positive results in COVID-19 patients [1003, 143,142,141,146].**
7. Glutathione therapy has also shown positive results in some COVID-19 patients [128, 146].

5. Dexamethasone:

Dexamethasone suppresses Pro-inflammatory Cytokines in Severe COVID-19 patients. **Dexamethasone and was found to be beneficial in patients who were receiving either invasive mechanical ventilation or oxygen alone, but not among those who were not receiving any respiratory support [161,9,1003].**

6. Ulinastatin:

1. Ulinastatin inactivates the extracellular elastase excreted from neutrophils and also suppresses the production of activated elastase [178]. Ulinastatin inhibits (polymorphonuclear neutrophils) PMNs activity and reduces the systemic inflammatory responses [183].
2. Ulinastatin has a confirmed powerful efficacy in inhibiting the release of inflammatory factors, removing oxygen free radicals, improving microcirculation and tissue perfusion, and alleviating endothelial injuries [180,173,181,182].
3. Ulinastatin decreases proinflammatory cytokines during systemic inflammatory response syndrome (SIRS) and associated sepsis [169,174,2032].
4. Ulinastatin inhibits the production of inflammatory markers like Serum C reactive protein(CRP), tumor necrosis factor-alpha (TNF-alpha), interleukin-6 (IL-6), and enhances the anti-inflammatory cytokines in the treatment of SIRS [171].
5. Ulinastatin ameliorates Sepsis, associated multiple organ dysfunction syndrome (MODS) and reduces mortality [182,187,162].
6. Ulinastatin reduces LPS induced inflammatory responses [188,172].
7. Ulinastatin inhibits coagulation and endothelial leakage [178,180].
8. Zhao et.al demonstrated that ulinastatin inhibited the hepatic hypoxia/reoxygenation (H/R) injury in Chang liver cells, and concluded that it might be due to autophagy activation [192].
9. Ulinastatin reduces HMGB-1 expression [190,191,192].
10. Neutrophils and associated NET's have been implicated with SARS-COV-2 mediated damage in COVID-19 patients [598,597,1448,1449].
11. **Huang et.al reported that Ulinastatin showed better results on 7th day in COVID-19 patients by preventing lymphocyte decrease, CRP and improving oxygen saturation [2031].**

7. Aerosol/ Nebulized Ribavirin Therapy :

1. **Aerosol Ribavirin has been reported to be reversing parenchymal thickening and multiple ground glass opacity associated areas in lungs of COVID-19 patients when used early [39].**
2. Aerosol Ribavirin has been reported to be safe in COVID-19 patients [39].

8. CD24:

1. Inhibits NF-KB mediated pro-inflammatory responses [752,753,732].
2. Enhances self and non-self discrimination and promotes CD8+ T cell activity [754,670,729].
3. **Binds to HMGB-1 and reduces HMGB-1 and MDSC mediated immunosuppression on CD8+ T cells [488,685,755].**
4. One stop solution for preventing Lymphopenia and Sepsis in severe COVID-19 patients.

9. Anti-HMGB-1:

1. Anti-HMGB-1 treatment might reduce HMGB-1 mediated pro-inflammatory responses and reduce subsequent HMGB-1 mediated MDSC recruitment during viral infections especially IAV [351,352, 353, 409,261].
2. Anti-HMGB-1 treatment prevents Lymphopenia [425,517].
3. Anti-HMGB-1 treatment provides protection against systemic inflammatory response syndrome (SIRS) induced Sepsis [504,535].

10. Remdesivir-IV:

1. Reduces SARS-COV-2 Viral replication and viral load during early stages [50,51,52,53].

11. Monoclonal Antibodies Therapy:

1. Neutralizing monoclonal antibodies (mAb) therapy is useful only if administered at early stage in COVID-19 patients with mild/moderate symptoms [2056,2057,2048-2051].

12. Nebulised Interferon -I and III therapy:

1. Nebulised Interferon Therapy at earlier stages is reported to be successful for COVID-19 patients while late stages might not be helpful [1115-1119, 2043-2047].

13. Nebulized Unfractionated Heparin (UFH):

1. Nebulized Unfractionated Heparin might target SARS-COV-2 mediated Lung Injury, fibrin deposition, Thrombosis, dead-spaces and hypoxaemia, Ventilation mediated injury [2094-2133].
2. Nebulized Unfractionated Heparin is useful in treating ARDS [2131].
3. Nebulized Unfractionated inhibits conformational change required by SARS-COV-2 and prevents entry into host cell and subsequent viral replication by destabilizing RBD [2101-2121].

14. Doxycycline:

1. Usage of Doxycycline might be effective only in patients with confirmed secondary bacterial infections especially in critical and aged patients [2059, 2060,2061,2062,2063, 2064,2065].
2. Antibiotics are found to be dysregulating gut microbiota independent of the delivery Route i.e: administered either through oral or Intravenous ways [2058]. Antibiotics are known for dysregulating gut microbiota [1728] and gut microbiota is related to TLR-7 expression at mucosal surfaces [1704] and reduction in TLR-7 is associated with higher mortality in COVID-19 patients [616]. Wu et.al reported that TLR-7 ligands rescued the immune impairment in antibiotic-treated mice during Influenza virus (IAV) [1704].

15. TLR-3 and TLR-7 agonist:

1. In absence of TLR-7 MDSCs get recruited to Lung very quickly during Lung injury [615].
2. TLR-3 is essential for protection against Coronavirus family [830].
3. In, STAT-1^{-/-} mice, MDSCs get recruited swiftly during acute inflammation [896, 368].

16. Vitamin-D:

1. Daily dosage of Vitamin-D administration reduces susceptibility to respiratory virus by half but not a single high dose administration [2135].
2. **Daily high dose of Vitamin-D administration reduces Inflammatory Cytokines in COVID-19 patients [2148].**
3. **Daily high dose of Vitamin-D administration reduces fibrinogen in COVID-19 patients [2149].**
4. Vitamin-D upregulates cellular Glutathione (GSH) levels and reduces ROS levels [2158].

17. Flavanoids:

1. Lot of studies recommend the usage of flavanoids in COVID-19 treatment [2076, 2077, 2078, 2079, 2080].
2. Zhu and Xie et.al though their docking studies and in-vitro studies showed that Flavanoids have the potential in reducing SARS-COV-2 viral replication and associated cell death [2076, 2081].

18. Accidental causes in COVID-19 :

● Abuse of Steroids:

1. Dexamethasone treatment strongly enhances MDSC expansion through upregulation of miR-155 and miR-21 expression [1630, 368]. Dexamethasone or any immunosuppressants administration during early stages of COVID-19 compromises their immune systems ability to stop the virus [161]. As a result the virus can directly reach lungs and induce Alveolar type -II epithelial cell damage and subsequent collapse due to lack of Surface tension. Supportively enough in a COVID-19 case report Dexamethasone misuse has been showed to be associated with delayed viral clearance leading to occurrence of severe COVID-19 pneumonia [2086].
2. Although Steroids usage in elderly critically ill COVID-19 patients has been reported to be showing positive outcomes [2087, 161] it's misuse might show detrimental effects on the patients [2088].
3. Over usage of Steroids in COVID-19 patients especially in patients with Co-morbidities can make them susceptible to dangerous secondary infections like Mucormycosis [2089-2093].

● Abuse of Antibiotics:

1. Antibiotics are found to be dysregulating gut microbiota independent of the delivery Route i.e: administered either through oral or Intravenous ways [2058]. Antibiotics are known for dysregulating gut microbiota [1728] and gut microbiota is related to TLR-7 expression at mucosal surfaces [1704] and reduction in TLR-7 is associated with higher mortality in COVID-19 patients [617]. Wu et.al reported that TLR-7 ligands rescued the immune impairment in antibiotic-treated mice during Influenza virus (IAV) [1704].

2. Abuse of Antibiotics has been reported to be a key factor in worsening/aggravating the diseased condition in COVID-19 patients [2082,2083,2084,2085].

● **Damage due to Improper usage of Nasal swabs:**

1. While using Nasal swabs, excess usage of force and incorrect sampling techniques might create an injury in the nasal cavity [2066,2075] especially in people who underwent Sinus Surgery [2067]. This injury might pave way for SARS-COV-2 to escape into the blood stream directly. This can lead to systemic inflammation and multi-organ failure independent of the tissue damage in lungs or airways. If injury left unchecked might lead to blood clots and subsequent consequences.
2. There have been reported cases of Nasal swab induced skull base injuries and CSF leakages [2069, 2070,2071,2072,2073]. In one case Traumatic Cribriform Plate Defect have been observed following Self-administration of COVID-19 Nasal Swab Test [2074].

Description:

1. SARS-COV-2 uses disulfide confirmation:

SARS-COV-2 attaches to Nose airway epithelial cells [1102,1103]. Host TMRSS-2 helps in cleaving the SARS-COV-2 Spike S protein [1207,1208]. SARS-COV-2 trimeric Spike S glycoprotein along with its Receptor Binding Domain (RBD) attaches to Angiotensin-Converting Enzyme 2 (ACE2) receptor of the host epithelial cells [1204, 1207,1208]. SARS-COV-2 requires the conformational change of disulfide bonds present at the surface of host ACE2 receptor to exhibit favourable binding conditions and to facilitate further entry into the host epithelial cells [1104, 1209].

2. TMPRSS2 accelerates SARS-COV-2 entry:

The spike (S) protein of coronaviruses facilitates viral entry into target cells. Additionally, Hoffmann and coworkers found that infection by SARS-CoV-2, the virus responsible for COVID-19, may depend almost exclusively on the additional host cell factors like TMPRSS2 [145,137].

Manček et.al through their experiments showed that SARS-COV-2 Spike protein and ACE2 alone are sufficient for the formation of syncytia, this group also observed that TMPRSS2 (transmembrane protease serine 2) co-expression on ACE2 cells further promotes the syncytia formation, thus increasing the sensitivity of the system [135].

3. In-Silico/Computational analysis of SARS-COV-2 and ACE-2 interactions through disulfide confirmation:

Hati et.al through their computational studies reported that under severe oxidative stress the cell surface receptor ACE2 and RBD of the SARS-COV-2 Spike S proteins are likely to be present in oxidized form with predominantly more disulfide linkages because reduction of all these disulfides into sulfhydryl groups completely impaired the binding of SARS-COV-2 spike S protein with ACE2 receptor [1104]. Pre existing Oxidative stress has been one of the factors in COVID-19 pathogenesis. Additionally, Extracellular thiol-disulfide balance is affected in age dependent manner and it has been implicated to be important in COVID-19 pathogenesis [1203,1104].

Efficiency of different strains of virus in infecting humans depends upon the binding free energy of interaction between SARS-COV-2 RBD and human ACE2 receptor [1205,1104]. SARS-COV-2 Spike S protein has higher affinity for human ACE2 receptor when compared with SARS-COV-1 [1206,1104].

Additionally more disulfides at ACE2 receptor protein surface means faster conformational change and faster interaction between host cell and virus thus faster entry into the host cell. This can be accounted for more transmissible nature of SARS-COV-2. Hati et.al reported that reducing disulfides on SARS-COV-1 RBD didn't reduce the interaction of SARS-COV-1 with ACE2, but reducing disulfides on SARS-COV-2 RBD reduced the interaction of SARS-COV-2 with ACE2 receptor binding by reducing/preventing the binding to certain level [1104]. Hati et.al also reported that reducing disulfide bonds at both RBD and ACE-2 receptor might block the viral entry into the host cell [1104]. SARS-COV-2 also uses PH based conformational changes inside the cell for replication [1104].

4. Role of Oxidative stress induced disulfides in accelerating SARS-COV-2 and ACE-2 interactions:

Redox environment at the cell surface receptors in extracellular regions are maintained by thiol-disulfide equilibrium [1105, 1201, 1202]. More Oxidative Stress results in more disulfide formation at the surface of the ACE2 receptors (extra cellular) [1105, 1202].

5. Previous and SARS-COV-2 induced Oxidative Stress and related compounds further accelerates SARS-COV-2 entry into cells and promotes swift cellular damage:

SARS-COV-2 has been associated with manifesting lot of immune related pathways. One of them includes inducing severe oxidative stress and subsequent increase in ROS levels in the infected cells [144].

Additionally, The ORF-8 protein of SARS-CoV-2 induces endoplasmic reticulum stress and mediates immune evasion by antagonizing production of interferon [1600]. SARS-CoV-2 caused ER-stress-activated unfolded protein response leads to cell death [1601,1600,1602].

Endogenous deficiency of Glutathione has been implied as the most likely cause of serious manifestations and death in COVID-19 Patients [128]. Polonikov et.al hypothesized that in severe COVID-19 cases, SARS-COV-2 would probably manifest and lower the GSH levels by mediating the induction of higher ROS levels and greater redox status (ROS/GSH ratio) than milder cases [128].

Supportively enough, Glutathione therapy has been implied to show efficiently positive outcome in a case study of 2-(two) COVID-19 patients with SARS-COV-2 induced pneumonia [146].

6. ACE-2 and TMPRSS2 inhibitors (Bromelain) in human airway cells:

Sagar et.al reported that Bromelain reduces the expression of TMPRSS2 in Calu-3 and ACE-2 in normal bronchial epithelial (BEAS-2B) and lung adenocarcinoma (A549) cells[136]. Cysteine protease inhibitor (E-64) treatment further confirmed that Bromelain's cysteine protease activity could cleave/reduce the expression of ACE-2 and TMPRSS2 [136].

7. TMPRSS2 inhibitors also restrict SARS-COV-2 entry into the host cells:

Both NAC and Bromelain in Vero cells:

Akhter et.al through their experiments reported that Acetylcysteine was able to reduce only 58% of the disulfide linkages [133]. Akhter et.al showed that the treatment with Bromelain and Acetylcysteine alone each independently did not show complete viral inhibition but BromAc a combination of both Bromelain and Acetylcysteine displayed complete virus inactivation in a concentration dependent manner [133]. Conclusively, In in-vitro whole virus culture of both wild-type and spike mutants, SARS-CoV-2 demonstrated a concentration dependent inactivation from BromAc treatment but not from any of the single agents alone [133]. SARS-COV-2 uses both TMPRSS2 mediated disulfide confirmation outside the cell and PH-dependent confirmation inside the cells as discussed already [1104]. The disadvantage with this study is that author used Vero cells in their experiment which is Cathepsin L-dependent, and thus pH-dependent [139], this leaves room for experiments in the human pulmonary Epithelial cells as virus entry is TMPRSS2-dependent as well [133,1104].

8. The TMPRSS2 Inhibitors reduces SARS-CoV-2 Pulmonary Infection in mouse models:

Li et.al showed that the TMPRSS2 Inhibitor Nafamostat reduces SARS-CoV-2 Pulmonary Infection in Mouse Models of COVID-19 [140].

Mccord et.al reported that priming of SARS-COV-2 spike protein with ACE-2 was blocked by clinically proven protease inhibitors of the TMPRSS2, Camostat mesylate [145,146,137] and Nafamostat mesylate [137].

Li et.al assessed and showed that Nafamostat was protective against SARS-CoV-2 in vivo using two mouse models[140]. In mice sensitized to SARS-CoV-2 infection by transduction with human ACE2, intranasal nafamostat treatment prior to or shortly after SARS-CoV-2 infection significantly reduced weight loss and lung tissue titers [140].

Li et.al tested the same two serine protease inhibitors, camostat mesylate and nafamostat mesylate, for their ability to inhibit entry of SARS-CoV-2 [140]. Both camostat and nafamostat reduced infection in primary human airway epithelial and in the Calu-3 2B4 cell line, with nafamostat exhibiting greater potency [140]. Both intraperitoneal and intranasal nafamostat inhibited SARS-CoV-2 infection in vivo [140]. Li et.al concluded that among camostat and Nafamostat, Nafamostat showed relatively greater potency against MERS-CoV and SARS-CoV-2 [140].

Li et.al suggested that nafamostat pretreatment significantly reduced viral loads over the course of SARS-CoV-2 infection further highlighting the importance of timing for the in vivo efficacy of nafamostat.

Intra-Nasal Nafamostat in SARS-COV-2 mice model:

Li et.al observed that the intranasal nafamostat was effective in mice model treatment. Li et.al concluded that the effectiveness of intranasal nafamostat might be due to decreased time interval between nafamostat delivery and viral inoculation [140]. Li et.al opined that currently, there is no data regarding nafamostat stability in respiratory secretions following i.n.(Intra Nasal) administration [140]. It is possible that the fate of nafamostat is different in human airway secretions than that in plasma, potentially contributing to the different outcomes observed via i.n. or i.p. routes in their study [140]. It is also unknown how efficiently nafamostat is transported into airway secretions when delivered systemically, which may influence outcomes following i.n. versus i.p. administration[140]. Conclusively there is no proven data for effective use of inhalation mediated delivery of nafamostat to respiratory tracts in COVID-19 patients which might depend on lot of factors but it was found to show better results when compared with other routes at-least in mice models .

9. Disulfide inhibitors restrict SARS-COV-2 entry into human airway cells:

Manček et.al tested the hypothesis that disruption of disulfides within RBD of SARS-CoV-2 spike protein prevents the fusion, subsequent viral entry into the host cells and found it to be true in airway epithelial cells [135]. This is in confirmation with the earlier author Hati et.al's invitro and insilico analysis [1104]. In their experiments Manček et.al used different thiol-reactive registered drugs that can target the reduction of disulfide bonds [135]. Manček et.al found that NAC alone did not inhibit cell fusion between SARS-COV-2 and host cell but its derivative NACA [138], with more potent antioxidant properties, strongly inhibited the formation of syncytia [135]. This is in agreement with the other results that showed that using NAC alone cannot inhibit viral entry but can only help reduce disulfides and delay the entry process [133]. These results show that there is huge potential for super antioxidant to prevent the viral entry. Tempol a super antioxidant which might as well be a good choice [5].

Manček et.al also found that L-ascorbic acid effectively inhibited cell fusion [135]. Manček et.al also reported that glutathione failed to inhibit the entry of SARS-COV-2 [135]. Manček et.al proposed that **NACA, L-ascorbic acid, and JTT-705** efficiently inhibited the interaction in spike-ACE2 binding assay, implying that this group of compounds each separately have the potential to affect the direct interaction between SARS-COV-2 spike and ACE2 [135].

Manček et.al through their experiments showed that SARS-COV-2 Spike protein and ACE2 alone are sufficient for the formation of syncytia, this group also observed that TMPRSS2 (transmembrane protease serine 2) co-expression on ACE2 cells further promotes the syncytia formation, thus increasing the sensitivity of the system [135]. They further validated this observation by using camostat mesylate, a TMPRSS2 inhibitor [135]. Conclusively, SARS-COV-2 Spike protein and ACE2 alone are sufficient for the syncytia formation, and TMPRSS2 (transmembrane protease serine 2) co-expression on ACE2 cells further accelerates the syncytia formation. Conclusively, In order to inhibit the entry of SARS-COV-2 into host cell effectively, it's important to target both disulfides and TMPRSS2 at the same time.

Manček et.al observed efficient inhibition of viral entry after 24 hours of exposure to NACA and auranofin without cytotoxicity independently [135]. Manček et.al team also proved the Inhibitory activity of selected compounds in lung-derived A549 cells by infecting them with SARS-CoV-2 virus and by maintaining a stable expressing of ACE2 at an MOI of 1, which were pre-treated for 3 hours by the indicated concentrations of the proposed compounds (NACA) [135].

Tempol:

Manček et.al found that NAC alone did not inhibit cell fusion but its derivative NACA [138] which has more potent antioxidant properties, strongly inhibited the formation of syncytia [135]. Tempol a super antioxidant might be as well a good choice [5].

Tempol is a powerful antioxidant [2,4,58,73]. Tempol relieves lung injury in a rat model of chronic intermittent hypoxia via suppression of inflammation and oxidative stress [3]. Tempol is protective against Hypoxia-induced Oxidative Stress and Apoptosis [1].

Maio et.al reported that Tempol can inhibit the viral replication by potentially inhibiting the RdRp [7]. Kavita et.al through their experiments concluded that Tempol as a novel antioxidant might inhibit both activated T cell and antigen presenting cell derived cytokines production in-vitro from COVID-19 patients [6].

Tempol in COVID-19:

Peter et.al reported that early administration of Intranasal Tempol treatment in a single COVID-19 patients reduced nasal congestion by day 4-5 and was found to be asymptomatic by day 8. Although it's a single case report taken into account that powerful antioxidant can inhibit viral entry and taken that Tempol inhibits viral replication of SARS-COV-2 and taken into account the SARS-COV-2 induced Oxidative stress and associated cell death, Intranasal/Nebulized Tempol administration along with standard care can increase the outcome drastically.

Conclusively Bromelain as TMPRSS2 inhibitor can reduce both TMPRSS2 and ACE-2 expression in airway epithelial cells and in combination with NAC can provide even better results. Whereas NAC can only reduce the disulfides at the surfaces but NAC cannot alone inhibit the viral entry completely, which subsequently might delay the entry as discussed earlier. Adding a powerful antioxidant (super oxide) like NACA or Tempol to this combination can completely inhibit the viral entry. Tempol might also be a good choice.

10. NAC and good results in COVID-19 patients:

Cases with severe COVID-19-associated respiratory failure who have received standard of care and routine treatment along with NAC have been associated with encouraging results and positive outcome in COVID-19 treatment [1003]. Puyo et.al reported that IV- NAC has been found to be producing positive results [143].

Liu et.al reported that inhalation of N-acetylcysteine (NAC) solution through respiratory airway in a single patient with mechanical ventilation showed positive outcome [142].

In another case report, IV and oral Glutathione and alpha-lipoic acid are reported to be associated with successful treated in two COVID-19 patients with dyspnea [146].

Horowitz et.al proposed that Oral and IV glutathione, glutathione precursors (N-acetyl-cysteine) and alpha lipoic acid may represent a novel treatment approach for blocking NF- κ B and addressing "cytokine storm syndrome" and respiratory distress in patients with COVID-19 pneumonia [146].

In another report by Alamdari et al., the combination of methylene blue-vitamin C-NAC (1 mg/kg methylene blue, 1500 mg/kg vitamin C, 1500 mg/kg NAC), as last resort therapy, was administered to five critically ill COVID-19 patients with high serum level of nitrite, methemoglobin, and oxidative stress. Results of this small case serious trials also proved to be promising, as four out of five patients responded well to the treatment and recovered [141].

11. (Intravenous N-Acetyl-Cysteine) IV- NAC when administered properly might enhance COVID-19 patient's condition by reducing inflammatory cytokines:

IV-NAC has long been used to safely treat patients with acetaminophen overdose [119,120], and ARDS (Acute Respiratory distress syndrome) [121,122]. NAC was also found to reduce CRP (C-reactive protein) levels in several controlled clinical trials [115,116]. CRP elevation is a prominent risk factor for disease progression in patients infected with COVID-19 [117,118].

Ibrahim et.al showed that IV (Intravenous) NAC (N-Acetyl-Cysteine) administration was useful in the treatment of critical COVID-19 patients with elevated parameters. Ex: Elevated CRP, ferritin etc...[9]. Ibrahim and their group administered IV- NAC multiple times whenever the inflammatory markers were elevated in COVID-19 patients [9]. After admission with NAC they have observed subsequent decrease in the inflammatory markers rapidly [9]. Their NAC admission protocol shows different NAC administration durations (Number of days) for different patients depending on their inflammatory levels with the same dose of approx 600 mg NAC for every 12 hours in 8 patients (actual data can be found in Ibrahim et.al publication-[9]) [9]. The number of days NAC was administered in most of the COVID-19 patients ranged from as short as 2 days to as long as 9 days [9]. Although Two patients with an amount of 20,000 to 30,000 mg NAC administration were reported to be recovered in two days [9]. This can be considered as an NAC shock treatment [9]. From the above observations we can conclude that there is no generalized time within which NAC should be administered for observing favourable results in COVID-19 patients, but rather we can conclude that IV-NAC should be administered as advised by physician from patient to patient or case to case basis either continuously in long run or should be administered as a shock treatment in non-responding ARDS patients or in a discrete manner whenever required to suppress the pro-inflammatory cytokines or whenever the pro-inflammatory cytokines are elevated in the absence of IV-NAC administration [9].

Taher et.al conversely reported that IV-NAC administration showed positive impact but did not show significant results in the treatment of critical COVID-19 patients [1003]. Taher et.al in their study of 92 patients administered 47 patients with IV-NAC and treated the other 45 people as placebo. These

patients were followed up for 28 days [1003]. But in the study Taher et.al[1003] have followed only a 3-day treatment protocol [1003]. We have already seen in the above successful study of Ibrahim et.al [9] that temporary/single time administration of NAC can only produce temporary results by suppressing inflammatory responses temporarily when administered in critical COVID-19 patient [1003]. Supportively enough, Taher et.al also reported that temporary betterment of the COVID-19 patients was observed after following a 3-day treatment protocol just after 3 days but not in the final outcome [1003].

Conclusively enough, the difference in results might most likely be due to the fact that Ibrahim et.al [9] followed a protocol where the number of days NAC was administered in most of the patients ranged from as low as 2 days to as long as 9 days depending on the patients subsequent inflammatory response in the absence of NAC treatment [9].

Both studies have specified that some of the patients have used dexamethasone along with NAC during the course of their study. So dexamethasone might be working synergically along with IV-NAC as well. Using dexamethasone has already been proved to be useful in treating critical COVID-19 patients but not in mild cases [161]. Using dexamethasone at safer levels in combination with IV-NAC can provide much more better results rather than higher dosages of only dexamethasone alone as higher doses of dexamethasone are associated with higher risk of susceptibility to dangerous secondary infections. Early administration of Dexamethasone might not be useful for the patients as it might suppress the early inflammatory response that kills the infected cells and put the patient at risk of Virus mediated alveolar collapse [161].

The below images have been taken from Ibrahim et.al [9], the whole credit of this research goes to them and their group, if any data is required please refer to their publication or consult them [9]. The purpose of using this image is to show that NAC when administered continuously can show proper results in COVID-19 patients as proved by Ibrahim et.al [9].

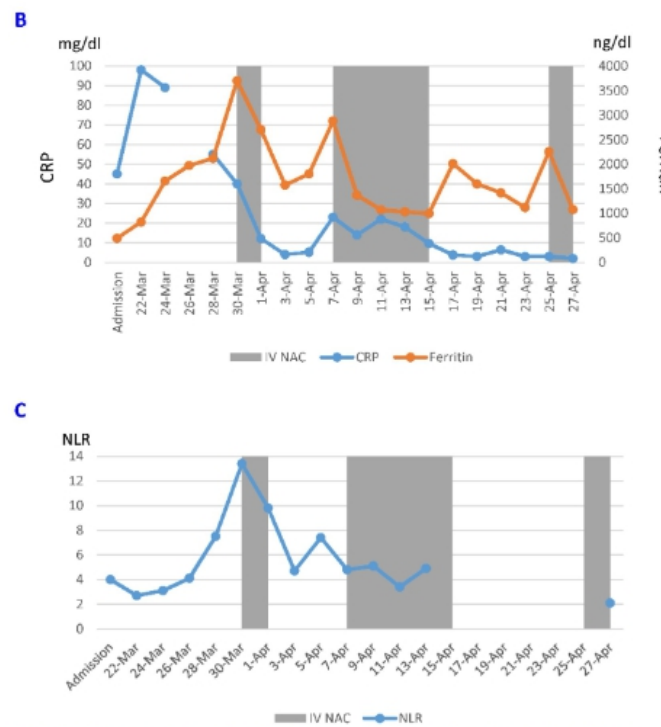


Fig. 1. Effect of IV NAC on clinical and laboratory outcomes in a G6PD-deficient patient infected by COVID-19. Gray shaded areas represent intervals of IV NAC administration. Initiation and termination of CC-ECMO are indicated along the horizontal axis with yellow and blue dots, respectively. A) Display of total and direct bilirubin levels. B) Tracking of CRP and ferritin levels. C) Monitoring of neutrophil/lymphocyte ratio (NLR). (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

Table 2

Effect of IV NAC on inflammation assessed by serum levels of CRP (mg/ml) and ferritin (ng/ml) and clinical outcome of COVID-19 infection in 9 patients without G6PD deficiency. *, $p = .0022$; **, $p = .0301$, using two-tailed paired *t*-test.

Patient (Age/Gender)	CRP before NAC	CRP after NAC	Ferritin before NAC	Ferritin after NAC	NAC duration	NAC dose (mg)	ECMO	Outcome
1(44/M)	89	14	3700	1500	2 days	30,000	Yes	Discharged home
2 (44/M)	90	13	9000	2000	2 days	20,000	Yes	Discharged Home
3 (48/M)	243	72	5900	2700	7 days	600 every 12 h	Yes	Discharged Home
4 (38/M)	280	26	4900	900	9 days	600 every 12 h	Yes	Hospitalized
5 (38/M)	46	5	1100	800	4 days	600 every 12 h	Yes	Discharged home
6 (42/M)	235	31	4000	2500	5 days	600 every 12 h	Yes	Hospitalized
7 (48/F)	99	45	300	330	4 days	600 every 12 h	Yes	Discharged Home
8 (48/M)	307	23	2700	1100	6 days	600 every 12 h	Yes	Discharged Home
9 (71/M)	145	71	2200	1800	5 days	600 every 12 h	No	Discharged home
10 (65/M)	63	11	2800	1800	4 days	600 every 12 h	Yes	Discharged home
Mean ± SD	160 ± 97	31 ± 24*	3630 ± 2526	1543 ± 762**				

Original author of the below images is [Ibrahim et.al- [9] with title as: "Therapeutic blockade of inflammation in severe COVID-19 infection with intravenous N-acetylcysteine.", Clin Immunol. 2020]-[9]

12. Dexamethasone in COVID-19:

Horby et.al reported that, In patients hospitalized with Covid-19, the use of dexamethasone resulted in lower 28-day mortality among those who were receiving either invasive mechanical ventilation or oxygen alone at randomization but not among those receiving no respiratory support [161]. Conclusively, Dexamethasone or associated immunosuppressants should not be used at earlier stages in COVID-19 unless the inflammatory markers are elevated.

These above studies collectively suggest that using IV NAC in severe COVID-19 patients along with Dexamethasone (only in critical patients) can provide good results.

13. Additional uses of NAC usage in Viral infections:

NAC can decrease ACE-II expression [125,126]. High-doses of N-acetylcysteine therapy for novel H1N1 influenza pneumonia has been found to be beneficial [127]. NAC was shown to inhibit NF- κ B activation in an in-vitro influenza (A and B) model [127]. In the context of influenza virus infection, NAC administration (100 mg/kg continuous iv. infusion daily for 3 days) was reported to promote clinical improvement in a woman with H1N1 influenza pneumonia; Oseltamivir was also employed during treatment [127]. N-acetyl-L-cysteine (NAC) inhibits mucin synthesis and pro-inflammatory mediators in alveolar type-II epithelial cells infected with influenza virus A and B and with respiratory syncytial virus (RSV) [129]. NAC might increase TLR-7 as well [131].

14. Ribavirin:

Reem et.al treated COVID-19 patients with a combination of Darunavir/ Cobicistat and Ribavirin [40]. His group found that this combination of Darunavir/ Cobicistat and Ribavirin although showed faster viral clearance by day 7, 14 and 28 compared to darunavir/cobicistat alone, but could not show any statistical difference [40].

Reem et.al report of faster viral clearance at day 7 which can be credited to both Darunavir/ Cobicistat and Ribavirin combination but the viral clearance at day 14 can be credited to Ribavirin alone [40]. Since this study has been conducted in Middle east we can assume that there might be some immune dysregulations due to excessive smoking of people [40, 45]. This immune dysregulation might have suppressed the advantages of Ribavirin in final outcome of severe patients.

15. Aerosole Ribavirin Therapy:

Ribavirin inhibits RNA synthesis by disrupting the activity of viral RNA-dependent RNA polymerases (RdRp), crucial enzymes in the life cycle of coronaviruses, and also inhibits mRNA capping [61,62,63,39]. Ribavirin has been used against RdRp of the hepatitis C virus [63], and orally administered ribavirin (in combination with other medications) is approved by the US Food and Drug Administration (FDA) and European Medicines Agency for the treatment of chronic hepatitis C infection [64,65,39]. Additionally Powdered Ribavirin has been shown to be efficiently delivered to lungs in patients with COPD and subsequent viral induced exacerbations [49]. Ribavirin for inhalation solution (ribavirin aerosol) is approved by the FDA and Health Canada for the treatment of infants and young children with severe lower respiratory tract infections due to respiratory syncytial virus [66,67]. Aerosol administration of ribavirin has been shown to be effective against multiple variants of influenza [68,69,70]. Ribavirin 100 mg/mL administered using a more efficient nebulizer was effective in reducing mortality in a lethal influenza A virus mouse model [71]. Administration of ribavirin aerosol as recommended in the treatment of respiratory syncytial virus (20 mg/mL over 12 h) [66]. The results of a randomized, double-blind, placebo-controlled study support the feasibility and efficacy of using ribavirin aerosol treatment in infants requiring mechanical ventilation for respiratory failure caused by respiratory syncytial virus (RSV) infection [72].

a. Ribavirin and SARS-CoV-2:

In order to evaluate the effectiveness of ribavirin and other anti-polymerase drugs against SARS-CoV-2, a 2020 study used homology modeling to build the Wuhan SARS-CoV-2 RdRp and then assessed the binding properties of different antiviral compounds using molecular docking methods [63]. Authors concluded that ribavirin demonstrated tight binding to the SARS-CoV-2 RdRp and proposed that it could potentially interfere with protein synthesis, leading to viral eradication [63].

b. Ribavirin in COVID-19:

Aerosol Ribavirin has been made available in Italy for patients with COVID-19 as part of a compassionate use program and has been demonstrated to be effective by Messina et.al without any significant side effects [39].

Prior to patient's enrollment in the compassionate use program, the diagnosis of COVID-19 was confirmed by positive tests for SARS-CoV-2 and laboratory testing ruled out other bacterial, viral, and fungal etiologies including Legionella, pneumococcus, Chlamydia pneumoniae, Mycoplasma pneumoniae, tuberculosis, cytomegalovirus, human immunodeficiency virus, and aspergillosis [39].

Messina et.al in their study enrolled COVID-19 patients with SARS-CoV-2 induced parenchymal thickening and multiple ground glass areas in lungs [39]. The CRP (9, 75, 90, 7.8, 45 mg/L), Ferritin levels (301ng/mL, 617, 779, 420, -), IL-6 (0.6, 13.8, 31.8, 18.2, 17.3 ng/mL) in all these patients are high but not too much elevated [39]. One of the patient has been reported to be with obesity. Chest CT scans of all five patients showed to be present with multiple areas of parenchymal thickening and ground glass opacities [39].

Messina et.al (published on June 28, 2021) in their study of four (4) men and (1) one women with ages ranging from 29-72 years reported a successful clinical outcomes in administration of Aerosol Ribavirin for the treatment of SARS-CoV-2 [39]. Their group administered the patients with 100mg/ml of Ribavirin aerosol for 30 min twice daily for 6 days. (I.e: 12 doses) (For more information and data Please refer to original data from original author's publication -Messina et.al-[39]) [39].

Messina et.al reported that Aerosol Ribavirin either reversed the multiple areas of parenchymal thickening and ground glass opacities in the lungs of almost all COVID-19 patients and prevented their disease condition from becoming worsen [39]. Messina et.al has further confirmed this through respective CT-scans images of all the enrolled and Aerosol Ribavirin administered patients.

Aerosol Ribavirin prevented the patients from getting admitted to ICU's. [39]. All patients were observed to be recovered fully, and nasopharyngeal swabs obtained after hospital discharge tested negative for SARS-CoV-2 [39]. Ribavirin aerosol appears to be efficacious in the treatment of patients with COVID-19. Messina et.al did not observe any adverse reactions to Ribavirin treatment in any of the five patients [39].

Administration of ribavirin Aerosol 100 mg/mL for 30 min is estimated to deliver 1760 lg/mL to the alveolar lining fluid, which is approximately 64 times the half maximal response (EC50) of 26.7 lg/mL observed against a clinical isolate of SARS-CoV-2 in vitro (for data, please check the original publication by Messina et.al-[39]) [39].

There are other studies that confirmed and demonstrated the effectiveness of Ribavirin treatment in COVID-19. In vitro research has demonstrated the antiviral efficacy for lopinavir and ribavirin against SARS-associated coronavirus, and a clinical study showed that patients with probable SARS-CoV-2 treated with a combination of lopinavir/ritonavir, ribavirin (oral or intra- venous), and corticosteroids (n = 41) had a significantly lower rate of adverse clinical outcomes (i.e., acute respiratory distress syndrome or patient mortality) than a historical control group treated with ribavirin and corticosteroids alone (n = 111; P\ 0.001) [79,39].

Supportively enough, Zhou et.al reported the successful use of intravenously administered Ribavirin (3 times daily for 14 days) in a 38-year-old man diagnosed with COVID-19 provided positive outcome [77]. After the treatment Zhou et.al reported that Chest CT scans revealed resolution of previous pneumomediastinum and a reduction of parenchymal consolidation with pulmonary fibrosis and pneumatocele in the inferior left lower lobe of the patient [77]. RT-PCR was negative on day 30, and the patient was found to be discharged for outpatient follow-up [77]. Zhou et.al reported that intravenously administered Ribavirin was used as one of the component of medical therapy that also included antibiotics, antitussives, bronchodilators, and interferon-a1b [77,39].

A 2020 open-label, randomized, phase 2 trial in hospitalized patients with COVID-19 evaluated 14-day combination therapy (n = 86) with orally administered lopinavir/ ritonavir, orally administered ribavirin, and subcutaneously administered interferon-b1b (in the subset of 52 patients admitted less than 7 days from symptom onset) compared with a control group that received only orally administered lopinavir/ritonavir (n = 41) [78,39]. That study found that the combination treatment was significantly better for alleviating symptoms, reducing viral load, and shortening the duration of hospitalization [78].

Although side effects associated with Ribavirin must be taken into account as it happens to be that side effects might occur in different people with different drugs and their combinations. Scientists and Physicians should look into the safety profile of drugs while administering them.

c. Ribavirin and Pre-cautious measures to be taken :

Health care workers should be careful when using an aerosol treatment in patients infected with SARS-CoV-2 because of increased risk of healthcare providers being exposed to the virus. It is known that the drug can disperse into the bedside area during treatment with ribavirin aerosol [66, 39], and the extent to which treatment may also impact virus dispersal into open air is unclear. In addition to the standard precautions taken when treating patients with COVID-19, it is recommended that healthcare providers should wear a facemask (as well as eye protection, gloves, and a gown), close the door to the patient room, and remain at a safe distance (possibly outside the door) during all types of nebulizer used treatments [80,39].

16. Ulinastatin for rescuing from SIRS, Inflammation mediated Injury and Sepsis:

Urinary trypsin inhibitor (Ulinastatin, UTI) is a nonspecific and multivalent Kunitz-type serine protease inhibitor purified from human urine [176]. It is capable of suppressing various serine proteases such as trypsin, plasmin, neutrophil elastase and chymotrypsin [177,178], and can also effectively stabilize lysosomal and cellular membranes [179]. Ulinastatin has confirmed powerful efficacy in inhibiting the release of inflammatory factors, removing oxygen free radicals, improving microcirculation and tissue perfusion, and alleviating endothelial injuries [180,173,181,182].

Sepsis is a common cause of morbidity and mortality in critically ill patients, and its incidence is increasing worldwide annually [163,164,162]. The pathogenesis of sepsis is complex and is believed to be initiated by the interaction between pathogen-associated molecular patterns and pattern recognition receptors on host immune cells [165,166,162]. This process sets off a series of pro-inflammatory mechanisms including synthesis and release of cytokines and complement, chemotaxis and activation of neutrophils, and initiation of coagulation [165-167,162]. **Current scientific opinion suggests that the systemic inflammatory response syndrome (SIRS) that characterizes severe sepsis results from an excessive activation of pro-inflammatory mediators, which have pleiotropic effects that overwhelm the body's anti-inflammatory mechanisms, leading to widespread vascular, endothelial, and organ dysfunction that is often fatal [165–168,162,181].**

a. Ulinastatin usage in SIRS, endothelial damage, Multi organ dysfunction Syndrome and Sepsis:

Ulinastatin improves the survival of septic mice by suppressing pro-inflammatory responses and lymphocyte apoptosis [169, 174,2032]. Ulinastatin provides protective effect against murine models of sepsis by inhibiting TNF- α and IL-6 [170,181]. Ulinastatin is protective against LPS mediated inflammatory responses [172]. Urinary trypsin inhibitor suppresses excessive generation of superoxide anion radical, systemic inflammation, oxidative stress, and endothelial injury in endotoxemic rats [173].

Zhang et.al conducted a trial on sixty patients and reported that Ulinastatin significantly improves the inflammatory symptom and signs of (systemic inflammatory response syndrome) SIRS, such as Temperature (T), heart rate (HR), respiration rate (RR) and white blood cell (WBC) count and inhibits the production of inflammatory markers like Serum C reactive protein(CRP), tumor necrosis factor-alpha (TNF- α), interleukin-6 (IL-6), and enhances the anti-inflammatory cytokines in the treatment of SIRS [171].

Ulinastatin can also effectively prevent the progression of SIRS towards multiple organ dysfunction syndrome (MODS) [171].

In their pilot study, Karnad et.al showed that intravenous administration of Ulinastatin reduced mortality in patients with severe sepsis [162].

Wang et.al conducted a trial to evaluate the effects of ulinastatin on mortality and related outcomes in sepsis patients [187]. Thirteen randomized controlled trials and two prospective studies were published by their team. This study included 1358 patients with sepsis, severe sepsis, or septic shock and were evaluated for the outcome when administered with Ulinastatin [187].

Wang et.al reported that Ulinastatin significantly decreased the all-cause mortality, Acute Physiology and reduced the incidence of multiple organ dysfunction syndrome (MODS). Wang et.al reported that Ulinastatin also decreased the serum levels of IL-6, TNF- α and increased the serum levels of IL-10. Wang et.al found that Ulinastatin administration did not lead to any difference in the occurrence of adverse events [187]. **Wang et.al concluded that Ulinastatin improved all cause mortality and other related outcomes in patients with sepsis or septic shock [187].**

The results of this meta analysis suggested that ulinastatin may be an effective treatment for sepsis and septic shock [187].

Li et.al found that Ulinastatin attenuates LPS-induced inflammation in mouse macrophage RAW264.7 cells by inhibiting the JNK/NF- κ B signaling pathway and activating the PI3K/Akt/Nrf2 pathway [188].

b. Ulinastatin downregulates HMGB-1 expression and pro-inflammatory cytokines:

Ying et.al reported that Ulinastatin preconditioning attenuates Inflammatory reaction of Hepatic Ischemia Reperfusion Injury in Rats via High Mobility Group Box 1 (HMGB-1) Inhibition [189]. Ying et.al through their experiments showed that pretreatment with ulinastatin attenuated liver ischemia reperfusion (IR) injury by reducing HMGB1 expression through its anti-inflammatory effects [189]. Wang et.al showed that Ulinastatin treatment significantly downregulates HMGB1, TNF- α and IL-6 expression [190].

Such effects of Ulinastatin inhibiting HMGB-1 expression and HMGB-1 mediated inflammatory responses has been reported by other authors [190,191]. Zhao et.al demonstrated that ulinastatin inhibited the hepatic hypoxia/reoxygenation (H/R) injury in Chang liver cells, and concluded that it might be due to autophagy activation [192].

Additionally, Sun et.al observed that Glutamine combined with ulinastatin treatment can alleviate damage to intestine after severe burn injury, lower the serum level of inflammatory cytokines, promote wound healing, and reduce the incidence of burn sepsis [193]. Sun et.al reported that Ulinastatin can weaken the immunosuppressive function mediated by splenic CD4(+) CD25(+) Tregs in severely burned rats, and improve proliferative function and secretory function of splenic CD4(+) T lymphocytes, and concluded that this effect may be attributed to the inhibiting effect of ulinastatin on the release of HMGB1 in large amount [193].

Ulinastatin ameliorates Pulmonary Capillary Endothelial permeability induced by Sepsis through protection of endothelial-tight Junctions via the inhibition of TNF- α and related pathways [182]. Ulinastatin may also protect endothelial cells from neutrophil-mediated injury not only by inactivating the extracellular elastase excreted from Neutrophils, but also by suppressing the production of activated elastase [178]. These pathways ultimately lowered the degrees of endothelial injuries and high permeability [178]. Ulinastatin might also modulate Tregs induction [186].

c. Ulinastatin reduces Neutrophil mediated damage:

In Kawasaki disease (KD), circulating neutrophils proliferate and are functionally activated as levels of reactive oxygen species and elastase increase [184]. This suggests that neutrophil-mediated injury of endothelial cells is involved in the pathogenesis of KD vasculitis. Takeshita et.al proposed that Ulinastatin (urinary trypsin inhibitor; UTI) inhibits neutrophil-mediated injury of endothelial cells in vitro, mainly by inactivating neutrophil elastase [184].

Ulinastatin inhibits (poly-morphonuclear neutrophils) PMNs activity and reduces the systemic inflammatory response [183]. Ulinastatin is an Elastase Inhibitor [185]. Ulinastatin reduces Neutrophils elastase [175].

Serine protease inhibitors induce their Inhibitory effect on neutrophil-mediated endothelial cell injury [178]. Neutrophils have been associated with devastating damage in viral immune responses [1399,1424,1029,1036]. Neutrophils mediate the Lung damage in ARDS and Acute Lung Injury [1013,1014,1028,1030-1036,1044,1045]. Pulmonary endothelial activation caused by extracellular histones contribute to Neutrophils Activation in ARDS [1015-1020,1026]. Ulinastatin also improves microcirculation during excessive hemorrhage [180].

Neutrophils are reported to be elevated in severe COVID-19 patients [194-199]. Elastase and exacerbation of neutrophil innate immunity are involved in multi visceral manifestations of COVID-19 [2033]. Additionally, Proteinase has been observed to be released from activated neutrophils in mechanically ventilated patients in both non-COVID-19 and COVID-19 pneumonia [2034]. Activated Neutrophils are associated with subsequent endothelial or Lung injury in COVID-19 [598,597,1448,1449,1451,1452,1453,1455,1419,1420,1421,1422,1012,]. Neutrophils associated Neutrophil extracellular traps (NET's) have been associated with thrombosis in COVID-19 pathogenesis [2035]. Neutrophils associated Neutrophil extracellular traps (NET's) have been associated with other negative outcomes in COVID-19 patients [2036, 2037,2038]. Mohamed et.al hypothesized that Ulinastatin administration at the earliest stage in COVID-19 patients might prevent Lymphopenia [2039].

d. Ulinastatin in COVID-19 Patients:

Huang et.al reported that high doses of Ulinastatin showed promising results in COVID-19 patients [2031]. Huang et.al treated Twelve hospitalized patients with confirmed SARS-CoV-2 infection, with high doses of ulinastatin [2031]. The average age of the patients in this study was 68.0 ± 11.9 years. Nine of the 12 patients (75.0%) had been reported to have one or more comorbidities [2031]. All 5 out 12 patients have been associated with decreased lymphocytes and 7 out of 12 patients have been associated with elevated C-reactive protein (CRP) levels (mean, 49.70 ± 77.70 mg/L) (for original data please look into original authors publication-Huang et.al - [2031]) [2031].

Huang et.al reported that the white blood cell levels and the percentage of lymphocytes returned to normal in all of the patients, and CRP decreased significantly and returned to normal in 10 out of 12 patients (mean, 6.87 ± 6.63 mg/L) on the seventh day after high dose Ulinastatin treatment (for original data please look into original authors publication Huang et.al - [2031]) [2031]. Huang et.al also reported that in 8 out of 12 patients the peripheral oxygen saturation was improved after treatment and prevented them from the requirement of mechanical ventilation or ICU admission [2031].

17. CD-24 for inhibiting pro-inflammatory responses and Lymphopenia:

CD24 acts as a rheostat of the cell and modulates the cell surface receptor signaling of diverse receptors [544,740]. CD24 is very important in regulating the cell fate [669]. CD24, Siglec-G/10 interactions are very important to discriminate between DAMPs and PAMPs [751]. CD24 Expression on T Cells is required for the Optimal Proliferation of T Cells in lymphopenic Host [729]. CD24 plays a very important role in inducing immune tolerance towards inflammation, CD24-Siglec-10 selectively repress tissue damage induced during inflammatory immune responses [752,753,732]. Additionally, reduced CD24 expression has been indicated as a marker of failure in Immune Tolerance [741, 735]. CD-24 will be a promising treatment given the fact that it has vital role in controlling the pro-inflammatory immune responses through inhibiting NF-KB. CD-24 can suppress cytokine storm and inhibit MDSCs immunosuppressive response mediated Lymphopenia. CD-24 can sense and bind to HMGB-1 [488]. CD24-Siglec-G/10 plays a very important role by discriminating between self and non-self during both innate and adaptive immune system induced responses [754].

a. CD24 in COVID-19 Patients:

CD-24 treatment in COVID-19 patients has been reported to be effective and is undergoing final phase trials [2040,2041].

18. Anti-HMGB-1:

a. Anti-HMGB-1 in Influenza:

High-mobility group box 1 (HMGB-1) protein is associated with negative outcome in the patient with severe influenza H5N1 virus infection [352]. Anti high mobility group box-1 monoclonal antibody treatment has been found to provide protection against influenza A virus (H1N1) induced pneumonia in mice [351,353]. Anti-high mobility group box-1 monoclonal antibody treatment is effective in ameliorating influenza infection and lipopolysaccharide induced brain edema [535].

Anti HMGB1 treatment is associated with reduced inflammation in models of experimental autoimmunity [409]. Anti-HMGB1 Neutralizing Antibody has been showed to attenuates Periodontal Inflammation in a Murine Periodontitis Model [261].

b. Anti-HMGB-1 in Sepsis:

Systemic T-Cell exhaustion dynamics is linked to Early High Mobility Group Box Protein 1 (HMGB1) driven Hyper-Inflammation in a Polytrauma Rat Model [425].

During peripheral tissue trauma HMGB-1 attenuates T-lymphocyte response and increases splenic CD11b (+) Gr-1 (+) myeloid-derived suppressor cells [517].

Anti-high-mobility group box protein 1 antibodies have been found to improve the survival chances of rats with sepsis [504].

Anti-HMGB1 monoclonal antibody ameliorates the immunosuppression after peripheral tissue trauma by suppressing myeloid-derived suppressor cells [517].

19. Monoclonal Therapy in COVID-19 patients:

Webb et.al conducted a trial of administering (Neutralizing monoclonal antibodies) mAb in 594 patients out of 7404 patients and reported that MAb treatment of high-risk ambulatory patients with early COVID-19 was well tolerated and likely effective at preventing the need for subsequent emergency department or hospital care [2048].

Piccicacco et.al reported that among high-risk COVID-19 patients with mild/moderate symptoms, early administration of mAbs potentially reduced the illness [2049]. The mortality rate was 0% in the mAb group compared with 3.5% in the control group. Patients treated with mAbs were significantly less likely to be hospitalized or visit the (emergency department) ED compared to patients not treated with mAb [2049].

Ganesh et.al through their observational study of 3596 patients reported that the use of bamlanivimab and casirivimab-imdevimab / mAbs in high-risk COVID-19 patients showed lower rates of hospitalization [2050].

Bariola et.al reported that the use of bamlanivimab monotherapy for outpatients with mild to moderate COVID-19 infection was associated with reductions in hospitalizations and mortality within 28 days [2051].

Latest Review regarding mAb therapy in COVID19 patients can be found here [2053]. Guidelines for mAb therapy can be found here [2054, 2055].

20. Nebulized Unfractionated Heparin (UFH):

Nebulized Heparin is useful in the treatment of inhalation induced injury in lungs [2094,2095,2096]. Glas et.al conducted a systemic search and found that Nebulized heparin was useful for patients under mechanical ventilation [2100] as an anticoagulant [2100]. The number of ventilator days and mortality at day 28 were observed to be reduced in patients treated with nebulized heparin when compared to patients in the control group [2100, 2128].

Juschten et.al conducted a systemic search of medical research and found that nebulized anticoagulants attenuates the pulmonary coagulopathy in preclinical studies with various models of lung injury, but their effects on inflammation was found to be less consistent [2129]. Viral induced damage in lungs or any other parts usually leads to thrombotic complications [2130]. SARS-COV-2 also induces such manifestations [2130]. Heparin is reported to be useful in the treatment of pulmonary microvascular thrombosis and hyaline membranes [2109]. Heparin has been observed to be widely used in the management of COVID-19 [2130]. A review presented that Heparin can be helpful as a multi targeting drug in the treatment in COVID-19 [2118].

COVID-19 is reported to be associated with the development of ARDS displaying the typical features of diffuse alveolar damage with extensive pulmonary coagulation activation resulting in fibrin deposition in the microvasculature and formation of hyaline membranes in the air sacs [2109]. The anti-coagulant actions of nebulised heparin may limit fibrin deposition and progression of lung injury and thrombosis [2109].

Pulmonary thrombosis is frequently seen in patients with COVID-19 pneumonia [2132,2133] and is associated with increased dead space and subsequent onset of severe hypoxaemia [2128]. Trials in patients with acute lung injury and related conditions found that inhaled UFH reduces the pulmonary dead spaces, coagulation activation, microvascular thrombosis and clinical deterioration, resulting in increased time free of ventilatory support [2103, 2097].

a. UFH inhibits SARS-COV-2 entry by destabilizing RBD:

Additionally, unfractionated heparin (UFH) is found to inactivate the SARS-CoV-2 virus and prevents its entry into host cells [2109]. Nebulisation of heparin may therefore limit both fibrin-mediated lung injury and inhibit pulmonary infection by SARS-CoV-2 [2109].

A number of studies found heparin competes with heparan sulphate for bacterial and viral adhesion and may therefore limit pathogen invasion. Heparin limits adhesion of a number of pathogens including *Pseudomonas aeruginosa*, *Burkholderia cenocepacia*, *Burkholderia pseudomallei*, *Legionella pneumophila*, *Staph aureus*, *Strep pyogenes*, *Strep pneumonia*, Respiratory syncytial virus and Influenza A virus (IAV) [2109-2116].

Various studies have demonstrated that UFH (Unfractionated Heparin) prevents SARS-associated coronavirus from attaching to and invading the host cells [2103,2099-2108]. Lan et.al showed that the treatment of cells with heparinase or exogenous heparin prevented the binding of spike protein to host cell ACE-2 receptor and inhibited SARS pseudovirus infection, demonstrating that cell-surface (heparan sulfate proteoglycans) HSPGs provide the binding sites for SARS-CoV invasion at the early attachment phase [2099]. Vicenzi et.al showed that heparin (100 microg/mL) inhibited infection of SARS-COV HSR1 strain in Vero cells by 50% [2101].

The antiviral activity of heparin is based on the affinity of viral glycoproteins to negatively charged glycosaminoglycans such as sulfated heparan, which are ubiquitously expressed on the surface of mammalian cells [2122].

Suryawanshi et.al through their In silico binding affinity studies revealed the possible binding sites of G1 and G2 peptides on (Heparan Sulfate) HS and ACE2, which are required for the SARS-COV-2 spike-HS and SARS-COV-2 spike-ACE2 interactions [2119].

A recent study by Courtney et.al demonstrated that the SARS-CoV-2 Spike S1 protein receptor-binding domain (RBD) attaches to UFH and undergoes conformational changes which may prevent SARS-COV-2 from binding to ACE-2 receptor and subsequent entry into the host cell [2098,2103].

Kim et.al reported that Glycosaminoglycan binding motif at S1/S2 proteolytic cleavage site on spike glycoprotein may facilitate novel coronavirus (SARS-CoV-2) host cell entry [2102]. Heparan sulfate interacts with the GAG-binding motif at the S1/S2 site on each monomer interface in the trimeric SARS-CoV-2 SGP, and at one another site when the receptor-binding domain is in an open conformation [2102].

Importantly, the binding of heparin to the receptor- binding domain (RBD) of the SARS-CoV-2 Spike S1 protein was found to be stronger for full-chain length heparin than low molecular weight heparins (LMWHs) [2102,2103].

Tandon et.al through their experiments using pseudotyped SARS-CoV-2 (spike glycoprotein) SGP on a third-generation lentiviral (pLV) vector showed that unfractionated heparin (UFH) and Enoxaparin Derivatives effectively Inhibits SARS-CoV-2 entry in a concentration dependent manner [2120].

Tree et.al observed that heparin binds and destabilizes the RBD protein of SARS-COV-2 and furthermore, they showed that heparin directly inhibits the binding of RBD of SARS-COV-2 to the human ACE2 protein receptor [2121].

Carina et.al conducted a viral plaque reduction assay in Vero E6 cells inoculated with a Dutch SARS-CoV-2 isolate in the absence/presence of various concentrations of heparin. Carina et.al observed that Heparin not only decreased the number of plaques but also decreased the size of plaques [2122]. Carina et.al reported that in the presence of 500–1,000 µg/ml heparin, viral replication is almost completely inhibited while at 125–250 µg/ml viral replication was suppressed by more than 60% [2122].

a. Nebulised UFH in ARDS Patients:

A trial was conducted by Dixon et.al in 252 patients with or at risk of acute respiratory distress syndrome (ARDS) while on Mechanical ventilation in intensive care unit [2131]. Dixon et.al wanted to see if Nebulised heparin can target fibrin deposition and limit the lung injury. Dixon et.al reported that compared with the placebo group, the heparin group had fewer cases of ARDS development to day 5 among the at-risk patients [2131]. Dixon et.al concluded that in patients with or at risk of ARDS, nebulised heparin administration showed less progression of lung injury and was well tolerated with earlier return to home but was not associated with improvement in self-reported performance of daily physical activities [2131].

Inhaled heparin has been associated with proven broad distribution in the respiratory tract including the alveolar space and useful during Acute Lung Injury [2123,2124,2125,2122].

Inhaled UFH reduces the pulmonary dead spaces, coagulation activation, microvascular thrombosis and clinical deterioration, results in increased time free of ventilatory support [2103,2097]. In addition, UFH has anti-inflammatory, mucolytic and anti-viral properties and, specifically, has been shown to inactivate the SARS-CoV-2 virus and prevent its entry into mammalian cells, thereby inhibiting pulmonary infection by SARS-CoV-2 [1103,2097].

Taken together the multi-range advantages offered by Nebulized UFH in terms of antiviral effects, anti-Coagulopathy and other advantages it might be useful in the treatment of severe COVID-19 patients [2127].

21. Vitamin-D:

Various studies have emphasized on the usage of Vitamin-D to see positive outcomes in COVID-19 patients. Moreover, Vitamin D administration has been associated with protection against respiratory viral infections including IAV.

Martineau et.al conducted an individual participant data meta-analysis of trials in more than a dozen countries, including the U.S., Canada, and the U.K. and found that daily or weekly supplementation had the greatest benefit for individuals with the most significant vitamin D deficiency (blood levels below 10 mg/dl) [2135]. Martineau et.al observed that regular vitamin D supplementation in these participants helped in cutting down the risk of respiratory infection by half and that all participants experienced some beneficial effects [2135]. Martineau et.al also observed that occasional administering of high doses of vitamin D in these participants did not produce any significant benefits [2134].

Goncalves et.al in their trial observed that the serum Vitamin-D levels quickly decrease after supplementation ended, suggesting a short-lived efficacy [2135]. Goncalves et.al reported that Vitamin-D supplementation in Elderly People with Influenza Vaccine administration significantly reduced the plasma level of TNF α and IL-6. Goncalves et.al also noted a significant decrease in the Th1/Th2 ratio in link with TNF α and IL-6 reduced levels which is in accordance with Penna et.al [2136] showing that Vitamin-D can inhibit Th1 differentiation (via expression of IFN- γ) and increase the Th2 response by stimulating IL-5 production [2136]. Vitamin-D supplementation was reported to be associated with an increase in TGF- β plasma levels after influenza vaccination, while no change in the Treg cell sub-population was observed [2135]. Martineau et.al reported that Vitamin-D supplementation has no effect on the humoral responses as there was no effect on Ab production in either seroprotection or seroconversion [2135]. This is consistent with other trials reports who showed that Vitamin-D has no effect on the humoral responses during Influenza vaccination [2137,2138]. Penna et.al reported that Vitamin-D inhibited NF-kappaB p65 phosphorylation and nuclear translocation in (myeloid dendritic cells) M-DCs but not in (plasmacytoid dendritic cells) P-DCs, suggesting a mechanism for the ability of Vitamin-D to modulate tolerogenic properties in M-DCs [2136].

Conclusively, Vitamin-D offers protection against respiratory viral infections [2139]. Vitamin-D deficiency is reported to be a risk factor for COVID-19 patients [2153,2155,2156,2157].

a. Vitamin-D usage in COVID-19 Patients:

There is an accumulating evidence that suggests that Vitamin-D supplementation might provide beneficial results in COVID-19 patients [2140,2141,2142,2143,2144,2147,2151,2152].

Jain et.al conducted analysis of vitamin D level among asymptomatic and critically ill COVID-19 patients and its correlation with inflammatory markers [2154]. Jain et.al reported that the fatality rate was high in vitamin D deficient (21% vs 3.1%) and Vitamin D levels are markedly lower in severe COVID-19 patients [2154]. Jain et.al concluded that Inflammatory responses were higher in vitamin D deficient COVID-19 patients [2154]. This all translates into increased mortality in vitamin D deficient COVID-19 patients.

Güven et.al conducted a study that included 175 COVID-19 patients with vitamin D deficiency and were hospitalized in the ICU. Vitamin D3 group included patients who received a single dose of 300,000 IU vitamin D3 intramuscularly. Vitamin D3 was not administered to the control group. Güven et.al concluded that Vitamin-D3 administration was not associated with improved hospital mortality results [2145].

Murai et.al in their randomized clinical trial that involved 240 hospitalized patients with moderate to severe COVID-19 patients, administered a single dose of 2,00,000 IU of vitamin D3 and compared them with the placebo. Murai et.al concluded that vitamin D3 administration did not significantly reduce the hospital length of stay [2146].

Rastogi et.al in their trial administered Vitamin-D in symptomatic or mildly symptomatic SARS-CoV-2 positive patients with vitamin D deficiency [2148]. Patients requiring invasive ventilation or with significant comorbidities were excluded in this trial [2148]. Intervention Participants were randomized to receive daily 60,000 IU of cholecalciferol (oral nano-liquid droplets) for 7 days in comparison with placebo (control group [2148]). Vitamin-D levels were assessed at day 7, and cholecalciferol supplementation was continued for those with less Vitamin-D in the intervention arm. SARS-CoV-2 RNA and inflammatory markers fibrinogen, D-dimer, procalcitonin and (CRP), ferritin were measured periodically [2148]. Rastogi et.al concluded that greater proportion of vitamin D-deficient individuals with SARS-CoV-2 infection turned SARS-CoV-2 negative with a significant decrease in inflammatory markers and fibrinogen at the end of high-dose cholecalciferol supplementation [2148].

Lakkireddy et.al through their randomized trial in 130 patients reported that daily supplementation of 60,000 IUs of vitamin D for 8 or 10 days depending upon their BMI in addition to the standard treatment showed positive results in mild to moderate COVID-19 patients [2149]. Lakkireddy et.al observed that Vitamin-D therapy significantly reduced the inflammatory markers without any side effects in COVID-19 patients [2149]. **In this trial it has been reported that no patient have received any drugs like Remdesivir, Favipiravir, Ivermectin or Dexamethasone** [2149]. Lakkireddy et.al concluded that mortality of COVID patients is almost zero if Vitamin D level was 60 ng/ml and it is very high if the levels are less than 30 ng/ml [2149]. Lakkireddy et.al reported that no adverse effects have been observed in the patients [2149].

De Carvalho et al. reported that mega doses (6,00,000 IU) of vitamin D administered through intramuscular route even in cases of nephrolithiasis are safe [2150].

Conclusively, Guven et.al administered single time higher dosage of 3,00,000 IU, Vitamin-D in Critical COVID-19 patients in ICU [2145] and Murai et.al administered single time higher dosage of 2,00,000 IU, Vitamin-D in moderate to severe COVID-19 patients [2146]. Both of these studies reported no positive outcomes.

Rastogi et.al administered daily 60,000 IU of Vitamin-D in symptomatic or mildly symptomatic COVID-19 patients [2148] and Lakkireddy et.al administered daily 60,000 IUs of Vitamin D for 8 or 10 days in mild to moderate COVID-19 patients [2149]. Both of these studies reported positive outcomes but no negative outcomes.

Previously, Martineau et.al has reported that occasional/single time administering of high doses of vitamin D in respiratory viral infection vulnerable candidates did not produce any significant benefits but regular vitamin D supplementation in the participants helped them in cutting down the risk of respiratory infection by half [2135]. Goncalves et.al in their trial observed that the serum Vitamin-D levels quickly decreased after supplementation ended, suggesting a short-lived efficacy of Vitamin-D supplementation [2135].

We can conclude that high doses of Vitamin-D therapy is not useful if administered in single dose but will be beneficial to every COVID-19 patient if administered daily until inflammatory markers were reduced (above studies indicate 8-10 days). Prolonged usage might create problems which should be taken care.

Irrespective of SARS-COV-2, Vitamin-D plays very important role as Vitamin D is important for the prevention of cardiovascular disease, diabetes, autoimmune diseases, and some cancers [2158]. Using a monocyte cell model, Jain et.al examined the hypothesis that vitamin D upregulates glutamate cysteine ligase (GCLC) and glutathione reductase (GR), which catalyzes Glutathione (GSH) biosynthesis. **Jain et.al reported that vitamin-D supplementation improves the cellular Glutathione (GSH) levels in cell culture studies [2158].** Jain et.al concluded that Vitamin-D upregulates glutamate cysteine ligase and glutathione reductase, and GSH formation, and decreases ROS and MCP-1 and IL-8 secretion in high-glucose exposed U937 monocytes [2158].

As there are lot of factors drive immune response in critical/severe COVID-19 patients the results of Vitamin-D supplementation might not be evident but taken the importance of Vitamin-D it has a beneficial role.

22. Remdesivir and COVID-19:

Although Remdesivir treatment in COVID-19 patients has shown some positive results [51,52,53] it might lead to negative outcomes/damaging effects in the patients if administered lately [54,55,56,57]. Remdesivir is effective and beneficial to COVID-19 patients in mainly reducing viral loads, slowing down the progression of pneumonia/ (Acute Respiratory Distress Syndrome) ARDS only if administered earlier/within the first 10 days of symptoms [50].

Simeprevir Potently Suppresses SARS-CoV-2 Replication and Synergizes with Remdesivir [46]. Remdesivir and Ledipasvir among the FDA-Approved Antiviral Drugs Have Potential to Inhibit SARS-CoV-2 Replication [47]. A preprint by Iart et.al reported that cobicistat synergizes with Remdesivir to inhibit SARS-CoV-2 replication [48].

Darunavir/ Cobicistat combination was found to be not effective in treating COVID-19 patients [41, 42]. Milic et.al reported that Darunavir/Cobicistat treatment is associated with negative outcome in HIV-Negative Patients with Severe COVID-19 Pneumonia [43]. Contrarily kim et.al reported a positive outcome in COVID-19 patients with usage of Darunavir/Cobicistat. But it's worth noting that kim et.al in his paper reported that their trial group has been comprised of patients with milder illness. This might lead a conclusion that Darunavir/Cobicistat is useful only at earlier stages of disease.

So we can conclude that administration of viral replication inhibitors are effective only if administered at an early stage just like Remdesivir.

23. Nebulised / IV- Interferon -I and III therapy:

Busnadiego et.al reported that antiviral activity of type I, II, and III Interferons counterbalances ACE2 inducibility and restricts SARS-CoV-2 [808].

Bessièrè et.al through their SARS-CoV-2 infected Syrian hamster model provided evidence that early type I IFN (IFN- α) treatment is beneficial, while late interventions are ineffective [1118]. Nakhband et.al through their systemic review based study reported that early administration of INF- α may be accounted as a promising treatment of COVID-19 in association with viral clearance and lower number of hospitalized days [1115].

a. IFN- β 1a in COVID-19 Patients:

Peiffer et.al conducted a small trial and reported that COVID-19 patients who received Nebulised (interferon) IFN- β 1a had significantly greater odds of clinical improvement [1116]. Higher or lower doses of IFN- β 1a in moderate to severe COVID-19 patients didn't show any improvement in terms of reducing mortality [1117]. Monk et.al in their trial administered Nebulized (interferon) IFN- β 1a. The median duration of COVID-19 symptoms before initiation of IFN- β 1a treatment in this study was reported to be approximately 10 days. The Interferon therapy administered group has both Co-morbid and more number of severe patients receiving oxygen therapy when compared to Control COVID-19 group. Monk et.al concluded that patients receiving IFN- β 1a (SNG001) had greater odds of improvement on the (WHO Ordinal Scale for Clinical Improvement) OSCI scale on day 15 or 16 and were more likely than those receiving placebo to recover [1119].

b. IFN- λ in COVID-19 Patients:

Jordan et.al reported that Peginterferon lambda IFN- λ accelerates viral decline in outpatients with COVID-19, increasing the proportion of patients with viral clearance by day 7, particularly in those with high baseline viral load [2046]. Peginterferon lambda has potential to prevent clinical deterioration and shorten duration of viral shedding [2046].

Jagannathan et.al in their study of a single dose of subcutaneous Peginterferon Lambda-1a (IFN- λ 1a) administration in uncomplicated COVID-19 patients reported that IFN- λ 1a neither shortened the duration of SARS-CoV-2 viral shedding nor improved symptoms in outpatients with uncomplicated COVID-19 patients [2047].

c. IFN- γ in COVID-19 Patients:

Lower Circulating Interferon-Gamma has been implicated as a Risk Factor for Lung Fibrosis in COVID-19 Patients [2043]. Myasnikov et.al conducted an open-label, randomized, low-interventional study, it included patients with moderate new coronavirus infection COVID-19 over 18 years of age of both sexes [2044]. In their study Myasnikov et.al administered IFN- γ at 500,000 IU, daily, once a day, during 5 days [2044] (for more details please refer to original authors article- Myasnikov et.al [2044]).

Myasnikov et.al concluded that IFN- γ in addition to complex therapy of the disease resulted in more favorable changes in the stabilization of vital signs, as well as in reduced length of fever and hospital stay by 2 days what allows suggesting a positive effect of this substance on the recovery processes in patients with moderate COVID-19 [2044]. Myasnikov et.al also reported that the patients who received recombinant IFN- γ experienced no progression of respiratory failure and required no transfer to intensive care unit [2044].

25. Accidental causes in COVID-19 :

1. Abuse of Steroids:

1. Dexamethasone treatment strongly enhances MDSC expansion through upregulation of miR-155 and miR-21 expression [1630, 368]. Dexamethasone or any other immunosuppressants administration during early stages of COVID-19 compromises their immune systems ability to stop the virus [161]. As a result the virus can directly reach lungs and induce Alveolar type -II epithelial cell damage and subsequent collapse due to lack of Surface tension. Supportively enough in a Single COVID-19 case report, Dexamethasone misuse has been showed to be associated with delayed viral clearance leading to the occurrence of severe COVID-19 pneumonia [2086].
2. Although Steroids usage in elderly critically ill COVID-19 patients has been reported to be showing positive outcomes [2087, 161] it's misuse might show detrimental effects on the patients [2088].
3. Over usage of Steroids in COVID-19 patients especially in patients with Co-morbidities can make them susceptible to dangerous secondary infections like Mucormycosis [2089-2093].

2. Abuse of Antibiotics:

1. Antibiotics are found to be dysregulating gut microbiota independent of the delivery Route i.e: administered either through oral or Intravenous ways [2058]. Antibiotics are known for dysregulating gut microbiota [1728] and gut microbiota is related to TLR-7 expression at mucosal surfaces [1704] and reduction in TLR-7 is associated with higher mortality in COVID-19 patients [618]. Wu et.al reported that TLR-7 ligands rescued the immune impairment in antibiotic-treated mice during Influenza virus (IAV) [1704].
2. Abuse of Antibiotics has been reported to be a key factor in worsening/aggravating the diseased condition in COVID-19 patients [2082,2083,2084,2085].

3. Damage due to Improper usage of Nasal swabs:

1. While using Nasal swabs, excess usage of force and incorrect sampling technique might create an injury in the nasal cavity [2066,2075] especially in people who underwent Sinus Surgery [2067]. This injury might pave way for SARS-COV-2 to escape into the blood stream directly. This can lead to systemic inflammation and multi-organ failure independent of the tissue damage in lungs or airways. If injury left unchecked might lead to blood clots and subsequent consequences.
2. There have been reported cases of Nasal swab induced skull base injuries and CSF leakages [2069, 2070,2071,2072,2073]. In one case Traumatic Cribriform Plate Defect have been observed following Self-administration of COVID-19 Nasal Swab Test [2074].

26. Flavanoids:

3. Lot of studies recommend the usage of flavanoids in COVID-19 treatment [2076, 2077, 2078, 2079, 2080].
4. Zhu and Xie et.al though their docking studies and in-vitro studies showed that Flavanoids have the potential in reducing SARS-COV-2 viral replication and associated cell death [2076, 2081].

Conclusions:

These above studies suggest that using combinations of several drugs either for inhibiting viral entry or reducing cellular death in severe COVID-19 patients along with their delivery through intranasal channel if possible can provide best results. This delayed viral burden and delayed time in damage induction can give enough time for the adaptive immune response to produce effective results.

This article is made as a part of the literature review and should not be used as a guide for the treatment of COVID-19 patients until approved by concerned authorities or until published in an renowned journal.

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