Matched Cohort Study on the Efficacy of Tocilizumab in Patients with COVID-19

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Abstract

Background: Tocilizumab has been proposed as a treatment for the new disease COVID-19, however, there is not enough scientific evidence to support this treatment. The objective of this study is to analyze whether the use of tocilizumab is associated with respiratory improvement and a shorter time to discharge in patients with COVID-19 and lung involvement.

Methods: Observational study on a cohort of 418 patients, admitted to three county hospitals in Catalonia (Spain). Patients admitted consecutively were included and followed until discharge or up to 30 days of admission. A sub-cohort of patients treated with tocilizumab and a sub-cohort of control patients were identified, matched by a large number of risk factors and clinical variables. Sub-cohorts were also matched by the number of other treatments for COVID-19 that patients received. Increment in SAFI (inspired oxygen fraction / saturation) 48 hours after the start of treatment, and time to discharge, were the primary outcomes. Mortality, which was a secondary outcome, was analyzed in the total cohort, by using logistic regression models, adjusted by confounders.

Results: There were 96 patients treated with tocilizumab. Of them, 22 patients could be matched with an equivalent number of control patients. The increment in SAFI from baseline to 48 hours of treatment, was not significantly different between groups (tocilizumab: -0.04; control: 0.09; p=0.636). Also, no difference in time to discharge was found between the two sub-cohorts (logrank test: p=0.472). The logistic regression models, did not show an effect of tocilizumab on mortality (OR 0.99; p=0.990)

Conclusions: We did not find a clinical benefit associated with the use tocilizumab, in terms of respiratory function at 48 hours of treatment, or time to discharge.

Introduction

A novel coronavirus (severe acute respiratory syndrome coronavirus 2, SARS-CoV-2) causing an epidemic outbreak was reported in Wuhan (China) in December 2019(1), being declared the outbreak as a pandemic on March 12, 2020(2). Although the global mortality rate is relatively low, it may be as high as 30% among the most severe affected patients(3).

A significant proportion of mortality in these patients is linked to severe respiratory deterioration (acute respiratory distress syndrome) caused by an excessive immune system activation, similar to the cytokine storm syndrome(4). Interkeukin-6, which production may be increased by SARS-CoV-2, plays a potential role in this syndrome. As a result, it has been hypothesized that tocilizumab, a recombinant humanized anti-interleukin-6 receptor monoclonal antibody, may have a beneficial effect on COVID-16 lung disease, especially in the most severe cases(4,5).

However, efficacy of tocilizumab in COVID-19 disease, has yet to be demonstrated. To date no results from randomized clinical trials testing tocilizumab have been reported and, the few observational studies which has a comparative group, report conflictive results on mortality or clinical improvement (6–9). Moreover, none of these observational studies has an exhaustive adjustment for confounding variables or has used tight matched controls for comparisons. This is in contrast with other observational studies, which have evaluated other treatments for COVID-19 (hydroxychloroquine or corticosteroids)(10–12) by using relevant matching technics, such as the propensity score (13).

In this study on hospitalized patients with COVID-19, we analyze the impact of tocilizumab on relevant clinical parameters, by using matching techniques based on brute-force algorithms to define the groups to be compared.

Design And Methods

Patients analyzed in this study are part of the COVID-19 cohort of the Consorci Sanitari de l'Alt Penedès i Garraf (CSAPG). CSAPG is a consortium which brings together three regional hospitals in Catalonia, Spain, with a total reference population of 247,357 inhabitants from the regions of Alt Penedès and Garraf. The COVID-19 cohort of the CSAPG is made up of 418 consecutive patients admitted from March 12, 2020, to May 2, 2020. In this cohort, patients without respiratory symptoms and patients with negative nucleic acid test for SARS-CoV-2 in a sample obtained by nasal smear, were excluded.

The investigators of the COVID-19 research group of CSAPG collected all data from the electronic medical records. The investigators collected sociodemographic data, comorbidities, previous chronic treatments and symptoms of presentation of COVID-19 disease. Moreover, every day since admission, the researchers recorded the vital signs of the patients, the inspired fraction of oxygen (FiO2) and all treatments given during the hospital stay. All blood tests and chest radiographs performed were also included in the database. Data were collected with the aid of a structured form created in the OpenClinica, version 3.1. (Copyright © OpenClinica LLC and collaborators, Waltham, MA, USA), following a common procedure on which all participants were previously trained. During the data collection process, quality controls were established on the data collected, correcting errors and retraining researchers, when necessary.

In the study hospitals, Tocilizumab was used both as a single dose of 600 mg intravenously, as well as in multidose regimens: initial dose of 600 mg, second dose of 400-600 mg at 12 hours, and a third optional dose of 400 mg (depending on the evolution of the patient). For the purposes of this study, all patients who received at least one dose were considered exposed to tocilizumab.

The primary outcomes were time to discharge and SAFI at 48 hours after start of treatment. SAFI is a parameter related with respiratory function, which was calculated using the following formula: saturation (%) / FiO_2(%). As secondary outcomes we studied the SAFI in the first 96 hours after treatment, and C-reactive protein (CRP) in the first 96 hours after the start of treatment.

In the statistical analysis, a subcohort of patients treated with tocilizumab was formed, and a control subcohort was matched with it (1:1 match ratio). The patients were matched by the following prognostic markers, which were identified in bivariate analyses and multivariate models in an initial step: sex, age, obesity, heart failure, chronic renal failure, and sleep apnea–hypopnea syndrome (SAHS). Follow-up of each patient started the day the patient took the first dose of a study drug. Follow-up of each control started the day after admission on which SAFI, vital signs (blood pressure, heart rate, and temperature), radiological involvement, and CRP were similar to those of the patient with whom they were matched. For this purpose, the CRP on day 1 of follow-up of the patient or, failing that, the day before the start of treatment, was taken as reference. Likewise, the radiological involvement on the treatment started, or any previous time up to a maximum of two days before the start of treatment, was considered. Missing data on radiological involvement were imputed in the following way: It was assumed that the radiological involvement on the days between two equal radiographs was the same as on the days of said radiographs (e.g., if a patient had an X-ray with three affected quadrants on day 1 and another with three affected quadrants on day 6, it was assumed that on all intervening days they had three affected quadrants). This interpolation was allowed up to a maximum interval of 6 days between radiographs. No missing data were imputed for other variables. Patients who received the study treatment and their controls were matched only if they had received the same other treatments for COVID-19, including hydroxychloroquine, lopinavir/ritonavir, azithromycin or tocilizumab. A margin of 3 days of lag at the start of the other treatments was tolerated between the patients under study and the matched controls. In the study hospitals, corticosteroids were also used as disease's treatment (mainly high doses of metilpredinosolone); in previous analysis we found no relationship between the use of these drugs and the study outcomes (data not shown), thus we allowed the subcohorts to not be paired by corticosteroids (which facilitated greater availability of controls who were more similar other characteristics of interest).

For pairing, a first step was performed using brute-force computing algorithms, which identified all possible controls in the database for each of the patients who received the study treatment. In this first step, controls were chosen who had the same sex and state of obesity ("yes" vs "no", according to the clinical history), the same radiological involvement (number of affected quadrants on anteroposterior radiography: 0–4) and an age difference not exceeding 15 ears. The control was allowed to have a SAFI from 1.1 points lower to 2 points higher than the treated patient and a CRP from 6 mg/dL lower to 4 mg/dL higher than the treated patient. The matching was then refined, choosing from among the previously identified potential controls the most similar in terms of SAFI, blood pressure, heart rate, and CRP by the propensity score. The same matching methodology has been used for the analysis of efficacy of other COVID-19 drugs in the CSAPG cohort (the results for other drugs will be published in independent papers).

The success of the matching was verified by comparing means or percentages between groups. Although the cohorts were paired by all relevant variables the first day of comparison, we wanted to rule out a different trend in the evolution of patients (improvement in one group and worsening in another). To do so, we verified that in both groups, the difference in the SAFI was similar between day 1 of analysis and the day before entering the analysis.

In the matched subcohorts, the SAFI was studied at 48, 72, and 96 hours using Student's t-test for independent samples and the time to discharge was analyzed using the log-rank test. In the SAFI analyses, patients with palliative sedation were excluded because in these patients SAFI is not related to the severity of the disease. In the analysis of time to discharge, deceased patients were excluded.

Due to the small sample size of the matched cohorts, association between tocilizumab use and mortality (proportion of events) was studied in the complete cohort, fitting logistic regression models, adjusted for other COVID medications (corticosteroids, hidroxicloroquin, azithromycin, lopinavir/ritonavir, interferon) and the following confounders: sex, age, obesity, heart failure, chronic renal failure, SAHS, baseline saturation in the emergency room, CRP in the emergency room, and quadrants affected in the emergency radiography.

For the statistical analysis, R software version 3.6.1 (R Project for Statistical Computing) and IBM SPSS statistics version 26 were used.

The research ethics committee reviewed the study and accepted the waiver of the patient's informed consent, as it was an observational and ambispective review of clinical data, and the patient's personal data were anonymized for its publication.

Results

Of the 418 patients included in the COVID-19 cohort of the CSAPG, a total of 96 (23%) patients were treated with tocilizumab. Of them, 22 patients could be paired with matched controls. The characteristics of the matched subcohorts are shown in Table 1.

Mean changes in saturation, FiO_2, and SAFI, in the first 48, 72 and 96 hours after the start of the treatment, both in treated and untreated subcohorts, are shown in table 2.

Comparing with control group, patients treated with tocilizumab presented a sustained CRP decrease after treatment. The absolute difference in CRP levels between groups were as follow: 199 mg/L at 48h ($p < 0.032$), 118 mg/L at 72h ($p < 0.010$) and 45.7 mg/L at 96h ($p < 0.006$).

The mean of follow up of the total patients included in the analysis was 8 days (interquartile range: 5 days). Time to discharge was not significantly different between treated and untreated patients (logrank: p=0.472). Kaplan-Meier curves for the time to discharge in the treated and control subchorts, are shown in Figure 1

Of the total cohort (N418), 79 patients died in the first 30 days after admission (18.9%). Adjusted logistic regression models, did not show an association between the use of tocilizumab and mortality: adjusted OR: 0.99 (IC95: 0.30-3.27); p=0.990.

Discussion

We were unable to find a benefit associated to the use of tocilizumab in terms of respiratory function (SAFI), time to discharge or mortality. However, we observed a significant decrease in CRP in patients treated with tocilizumab, which did not correlate with an improvement in the studied clinical parameters. In our opinion, this finding suggests that the effects of the drug on respiratory function, if any, are weaker than its biological effect on CRP.

Although our study is an observational trial, our adjustment method has been very exhaustive in defining similar groups in terms of baseline characteristics, clinical parameters of severity and associated anti-SARS-CoV-2 treatments. This level of adjustment differentiates our study from to date reported studies investigating the effect of tocilizumab on Covid-19.

Within the studies with comparative group, the study by Campochiaro and col. (65 patients, 32 of them treated with tocilizumab)(8) also did not find statistically significant benefits of the use of tocilizumab in terms of mortality nor in terms of clinical improvement. On the other hand, Capra and col. (85 patients, 62 of them treated with tocilizumab)(7) and Klopfenstein and col. (45 patients, 20 treated with tocilizumab)(6) found important benefits on mortality or intensive care unit admissions. In our opinion, the results of the latter studies are difficult to interpret, as no adjustment for confounders was made in Klopfenstein's work, and an incomplete adjustment by a limited number of factors, was made bay Capra and cols. Other than the level of adjustment, the mortality rate in the named studies (25-75%) was significantly higher than ours (only 3 patients died in the studied subcohorts), which pose another important difference with our work, which might indicate that our patients probably had a different clinical profile.

Given the observational nature of our study, the existence of residual confounders cannot be ruled out, as there is a greater probability that patients treated with tocilizumab, would have a higher-risk factors or disease severity. However, the exhaustive matching method used for studying the primary outcomes, and the verification of the comparability of the groups lead us to assume that this confounding effect was unlikely and, if there, was small.

Furthermore, the use of secondary data (obtained from the clinical history) might have led to information biases, as clinical data were not originally recorded for the purpose of this research. Nevertheless, given that the main variables were quantitative parameters, which were little influenced by the observers or their expertise in measurement, and given that these parameters are routinely and properly collected in clinical practice, we consider unlikely the existence of a relevant bias of this type.

Due to exhaustive matching, the final sample size of our comparison cohorts is small. This can lead to problems of generability, since our patients may not represent well the common of patients hospitalized for COVID-19 and, more importantly, to lack of statistical power, which may prevent appreciating existing differences between groups. The lack of statistical power also affected the study of mortality in the entire cohort, as can be seen in the width of the confidence intervals. However, given the similarity of the results means, the authors believe that, if tocilizumab has an effect on SAFI in the first 96 hours, on the time until discharge, or in mortality, this effect is not prominent (and, in any case, this effect should be less than its

biological effect on PCR, which we have been able to detect in our sample). Thus, the sample size and observational nature of our study warrant waiting for the results of randomized clinical trials to confirm ours.

In conclusion, in this observational study, we did not find evidence of a clinical benefit on post-treatment lung function (SAFI in the first 96 hours) or on length of the hospital stay, associated to the use of tocilizumab in patients hospitalized with COVID-19.

Declarations

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Author Contributions

ARM designed the study, contributed to data analysis and interpretation, drafted the manuscript and approved the final version.

CP designed algorithms for patient matching and aproved the final versión of the manuscirpt.

CG contributed to the study design, data interpretation and drafting the manuscript.

AM did the statistical analysis, reviewed and approved the final version of the manuscript.

OM, GFL, MTR, DD, SM, ER, IC and the COVID-19 research group of CSAPG, collected the data and reviewed and aproved the final versión of the manuscirpt.

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Competing interests

The authors declare no competing interests.

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Tables

TABLE 1. Baseline characteristics of patients treated with tocilizumab and the matched controls.

	Tocilizumab (n22)	Control (n22)	p
Age (years)	68.4	66.1	0.572
Men (n)	18	18	1.000
Obesity (n)	19	19	1.000
CHF (n)	0	1	0.312
CRF (n)	3	4	0.680
SAHS (n)	1	2	0.550
Saturation (%)	95.2	95.6	0.533
Systolic BP (mmHg)	127.5	130.5	0.568
Diastolic BP (mmHg)	71.8	72.9	0.702
HR (bpm)			
Temperature (°C)	36.4	36.6	0.300
SAFI[1]	3.0	2.8	0.429
SAFI trend[2]	-0.2	0.0	0.092
Radiographic involvement[3]	2.4	2.4	0.504
CRP (mg/dL)	11.5	13.3	0.512
Urea (mg/dL)	37.6 (n14)	38.6 (n13)	0.900
Hydroxychloroquine(n)	21	21	1.000
Lop/Rit (n)	21	21	1.000
Interferon (n)	2	0	0.488
Tocilizumab (n)	-	-	-
Methylprednisolone (n)	10	7	0.537
Dexamethasone (n)	6	1	0.095
Azithromycin (n)	16	18	0.721

CHF: congestive heart failure. CRF: chronic renal failure. SAHS: sleep apnea–hypopnea syndrome. BP: blood pressure. HR: heart rate. SAFI: saturation (%)/fraction of inspired O_2 (%). CRP: C-reactive protein.

[1] Maximum value 4.76, corresponding to 100% saturation with FiO_2 of 21%

[2] Change in SAFI with respect to the day before the start of the follow-up period.

[3] Number of affected quadrants in an anteroposterior chest radiograph. Range: 0–4 (0: no involvement; 4: involvement of the upper and lower lobes of both lungs)

TABLE 2. Increase in respiratory function parameters with respect to the first day of follow-up in patients treated with azithromycin, corticosteroids, and tocilizumab.

	Tocilizumab	Control	p
uration increase			
ıours	0.67 (n22)	-0.63 (n22)	0.104
ıours	0.44 (n20)	-0.64 (n21)	0.205
ıours	0.53 (n18)	-1.54 (n19)	0.124
$_2$ increase			
ıours	7.64 (n22)	1.71 (n22)	0.428
ıours	0.81(n21)	-2.30 (n21)	0.652
ıours	-1.85 (n20)	-2.35 (n19)	0.954
ᶠI increase			
ıours	-0.04 (n22)	0.09 (n22)	0.636
ıours	0.37 (n20)	0.31 (n20)	0.824
ıours	0.39 (n19)	0.26 (n19)	0.699

FiO_2: fraction of inspired oxygen

Figures

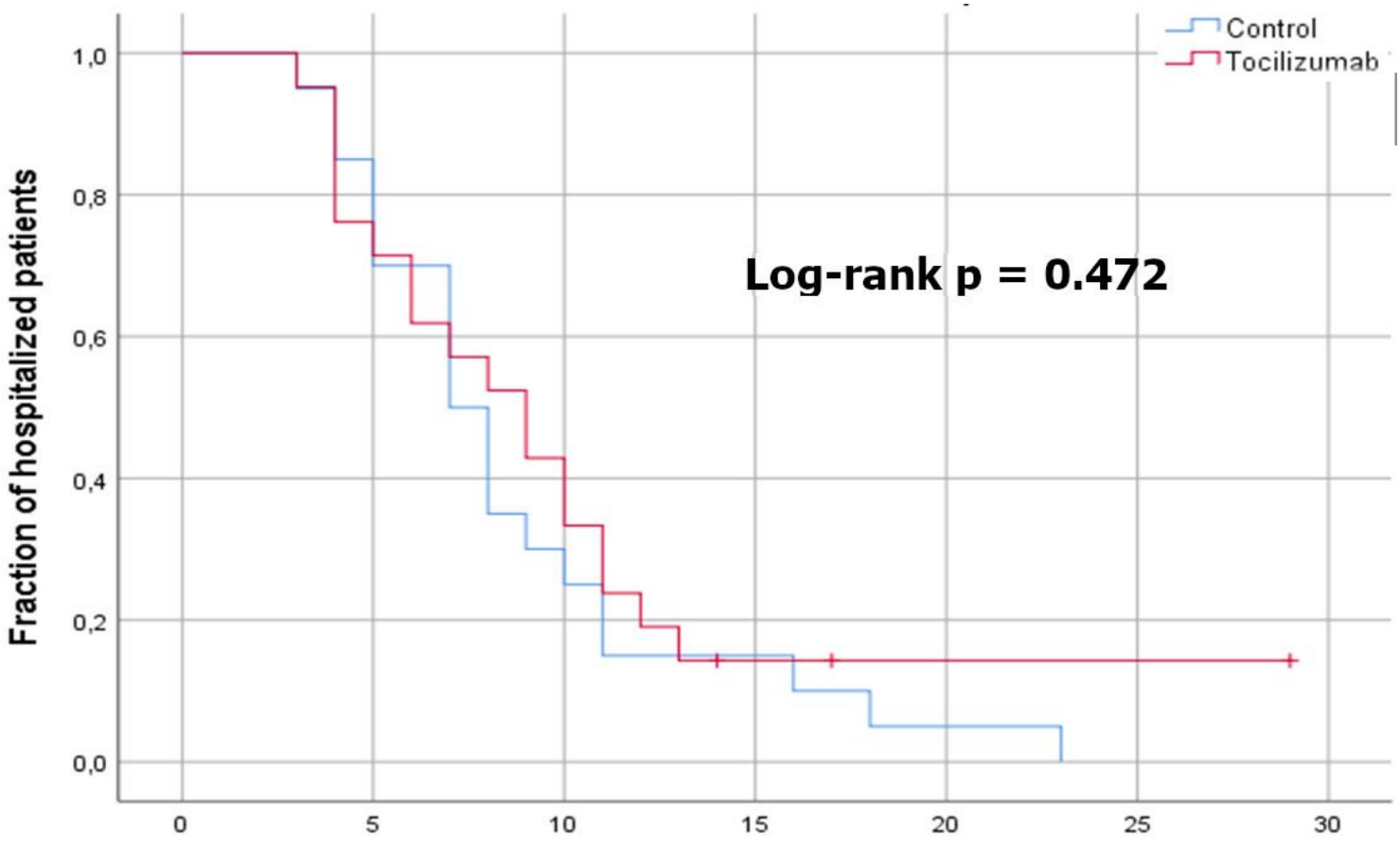

Figure 1

Time to discharge in tocilizumab treated patients and paired controls. Kaplan-Meier comparison curves and log-rank test.