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Hot Topic

Chloroquine and hydroxychloroquine as available weapons to fight COVID-19

Philippe Colson a,b, Jean-Marc Rolain a,b, Jean-Christophe Lagier a,b, Philippe Brouqui a,b, Didier Raoult a,b.∗

a Aix-Marseille Univeristé, Institut de Recherche pour le Développement (IRD), Assistance Publique–Hôpitaux de Marseille (AP-HM), MEPHI, 27 boulevard Jean Moulin, 13005 Marseille, France

b IHU–Méditerranée Infection, 19–21 boulevard Jean Moulin, 13005 Marseille, France

* Corresponding author. Present address: IHU–Méditerranée Infection, 19–21 boulevard Jean Moulin, 13005 Marseille, France. Tel.: +33 4 13 732 401; fax: +33 4 13 732 402.

E-mail address: didier.raoult@gmail.com (D. Raoult).
Repositioning of drugs for use as antiviral treatments is a critical need [1]. It is commonly very badly perceived by virologists, as we experienced when reporting the effectiveness of azithromycin for Zika virus [2]. A response has come from China to the respiratory disease caused by the new coronavirus (SARS-CoV-2) that emerged in December 2019 in this country. Indeed, following the very recent publication of results showing the in vitro activity of chloroquine against SARS-CoV-2 [3], data have been reported on the efficacy of this drug in patients with SARS-CoV-2-related pneumonia (named COVID-19) at different levels of severity [4,5]. Indeed, following the in vitro results, 20 clinical studies were launched in several Chinese hospitals. The first results obtained from more than 100 patients showed the superiority of chloroquine compared with treatment of the control group in terms of reduction of exacerbation of pneumonia, duration of symptoms and delay of viral clearance, all in the absence of severe side effects [4,5]. This has led in China to include chloroquine in the recommendations regarding the prevention and treatment of COVID-19 pneumonia [4,6].

There is a strong rationality for the use of chloroquine to treat infections with intracellular micro-organisms. Thus, malaria has been treated for several decades with this molecule [7]. In addition, our team has used hydroxychloroquine for the first time for intracellular bacterial infections since 30 years to treat the intracellular bacterium *Coxiella burnetii*, the agent of Q fever, for which we have shown both in vitro and then in patients that this compound is the only one efficient for killing these intracellular pathogens [8,9]. Since then, we have also shown the activity of hydroxychloroquine on *Tropheryma whipplei*, the agent of Whipple’s disease, which is another intracellular bacterium for which hydroxychloroquine has become a
reference drug [10,11]. Altogether, one of us (DR) has treated ~4000 cases of C. burnetii or T. whipplei infections over 30 years (personal data).

Regarding viruses, for reasons probably partly identical involving alkalinisation by chloroquine of the phagolysosome, several studies have shown the effectiveness of this molecule, including against coronaviruses among which is the severe acute respiratory syndrome (SARS)-associated coronavirus [1,12,13] (Table 1). We previously emphasised interest in chloroquine for the treatment of viral infections in this journal [1], predicting its use in viral infections lacking drugs. Following the discovery in China of the in vitro activity of chloroquine against SARS-CoV-2, discovered during culture tests on Vero E6 cells with 50% and 90% effective concentrations (EC<sub>50</sub> and EC<sub>90</sub> values) of 1.13 µM and 6.90 µM, respectively (antiviral activity being observed when addition of this drug was carried out before or after viral infection of the cells) [3], we awaited with great interest the clinical data [14]. The subsequent in vivo data were communicated following the first results of clinical trials by Chinese teams [4] and also aroused great enthusiasm among us. They showed that chloroquine could reduce the length of hospital stay and improve the evolution of COVID-19 pneumonia [4,6], leading to recommend the administration of 500 mg of chloroquine twice a day in patients with mild, moderate and severe forms of COVID-19 pneumonia. At such a dosage, a therapeutic concentration of chloroquine might be reached. With our experience on 2000 dosages of hydroxychloroquine during the past 5 years in patients with long-term treatment (>1 year), we know that with a dosage of 600 mg/day we reach a concentration of 1 µg/mL [15]. The optimal dosage for SARS-CoV-2 is an issue that will need to be assessed in the coming days. For us, the activity of
hydroxychloroquine on viruses is probably the same as that of chloroquine since the mechanism of action of these two molecules is identical, and we are used to prescribe for long periods hydroxychloroquine, which would be therefore our first choice in the treatment of SARS-CoV-2. For optimal treatment, it may be necessary to administer a loading dose followed by a maintenance dose.

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**Competing interests:** None declared.

**Ethical approval:** Not required.
References


Table 1

Main results of studies on the activity of chloroquine or hydroxychloroquine on coronaviruses

<table>
<thead>
<tr>
<th>Reference</th>
<th>Compound(s)</th>
<th>Targeted virus</th>
<th>System used for antiviral activity screening</th>
<th>Antiviral effect</th>
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<tbody>
<tr>
<td>[12]</td>
<td>Chloroquine</td>
<td>SARS-CoV</td>
<td>Vero (African green monkey kidney) E6 cells</td>
<td>$EC_{50} = 8.8 \pm 1.2 \mu M$</td>
</tr>
<tr>
<td>[16]</td>
<td>Chloroquine</td>
<td>SARS-CoV</td>
<td>Vero E6 cells</td>
<td>$EC_{50} = 4.4 \pm 1.0 \mu M$</td>
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</tbody>
</table>
| [17]      | Chloroquine, chloroquine monophosphate, chloroquine diphosphate | SARS-CoV (four strains) | Vero 76 cells | Chloroquine: $EC_{50} = 1–4 \mu M$  
Chloroquine monophosphate: $EC_{50} = 4–6 \mu M$  
Chloroquine diphosphate: $EC_{50} = 3–4 \mu M$ |
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<th>BALB/c mice Intraperitoneal or intranasal chloroquine administration, beginning 4 h prior to virus exposure: 50 mg/kg but not 10 mg/kg or 1 mg/kg reduced for the intranasal route (but not the intraperitoneal route) viral lung titres from mean ± S.D. of $5.4 \pm 0.5$ to $4.4 \pm 1.2$ in $\log_{10}$ CCID$_{50}$/g at Day 3 (considered as not significant)</th>
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<td>[18] Chloroquine, hydroxychloroquine</td>
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<td>Feline coronaviruses</td>
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<td>Chloroquine</td>
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<td>HCoV-229E-GFP (GFP-expressing recombinant HCoV-229E)</td>
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</tbody>
</table>

CCID$_{50}$, 50% cell culture infectious dose; CoV, coronavirus; EC$_{50}$, 50% effective concentration (mean ± S.D.); GFP, green fluorescent protein; HCoV, human coronavirus; MERS, Middle East respiratory syndrome; SARS, severe acute respiratory syndrome; S.D., standard deviation.

Supplemental Table 2: Anti-viral activity of Chloroquine

See also [1] (Table 1) for additional references.