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Remdesivir Key Study in Lancet April 2020 (Wang) Swept Under the Rug by Media & Fauci

"Remdesivir in adults with severe COVID-19: a randomised, double-blind, placebo-controlled, multicentre trial"

By Dr. Paul Elias Alexander
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Alexander COVID News evidence-based medicine 21 September 2022

Region: USA
Theme: Media Disinformation, Science and Medicine

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See highlighted passage & numbers and you can see why this study was hidden by Fauci & NIH cabal for with the flawed NIH study, it showed that Remdesivir FAILED in cutting deaths & it increased harms.

My take:

There is evidence that Fauci and NIH et al. tampered with the study protocol so that they could claim some benefit as the drug was showing ineffectiveness and safety failures. So if you look at the protocol adjustment below, they made a non patient important outcome (time to recovery), the primary outcome. These are real crooks!

Remdesivir has emerged as liver and kidney toxic and a failed EBOLA drug, failed! It was a drug in search of a disease and found one here due to Fauci and his 'standard of care'!

Remdesivir emerged as one of these ineffective and potentially harmful drugs yet was championed by the NIH/NIAID/US government as a prominent treatment. The LANCET's Wang et al. clinical trial results (below) were released on the very same morning that the US government's NIH trial results (Beigel et al., https://www.nejm.org/doi/10.1056/NEJMoa2007764) on remdesivir were released, and showed a failure of remdesivir and even skewed heavily towards harms.

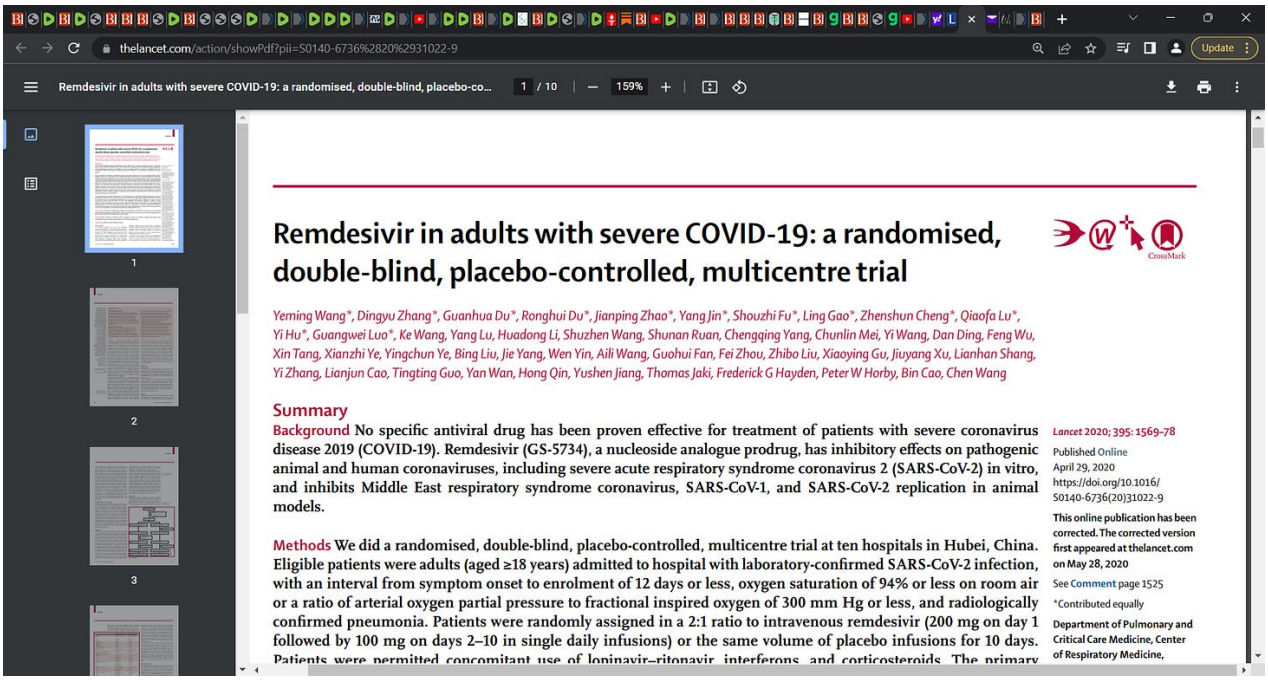
The key Wang et al.'s findings was that in adult patients admitted to hospital for severe COVID-19, "remdesivir was not associated with statistically significant clinical benefits." Furthermore, and very alarmingly, adverse events were reported in "102 (66%) of 155 remdesivir recipients versus 50 (64%) of 78 placebo recipients. Remdesivir was stopped early because of adverse events in 18 (12%) patients versus four (5%) patients who stopped

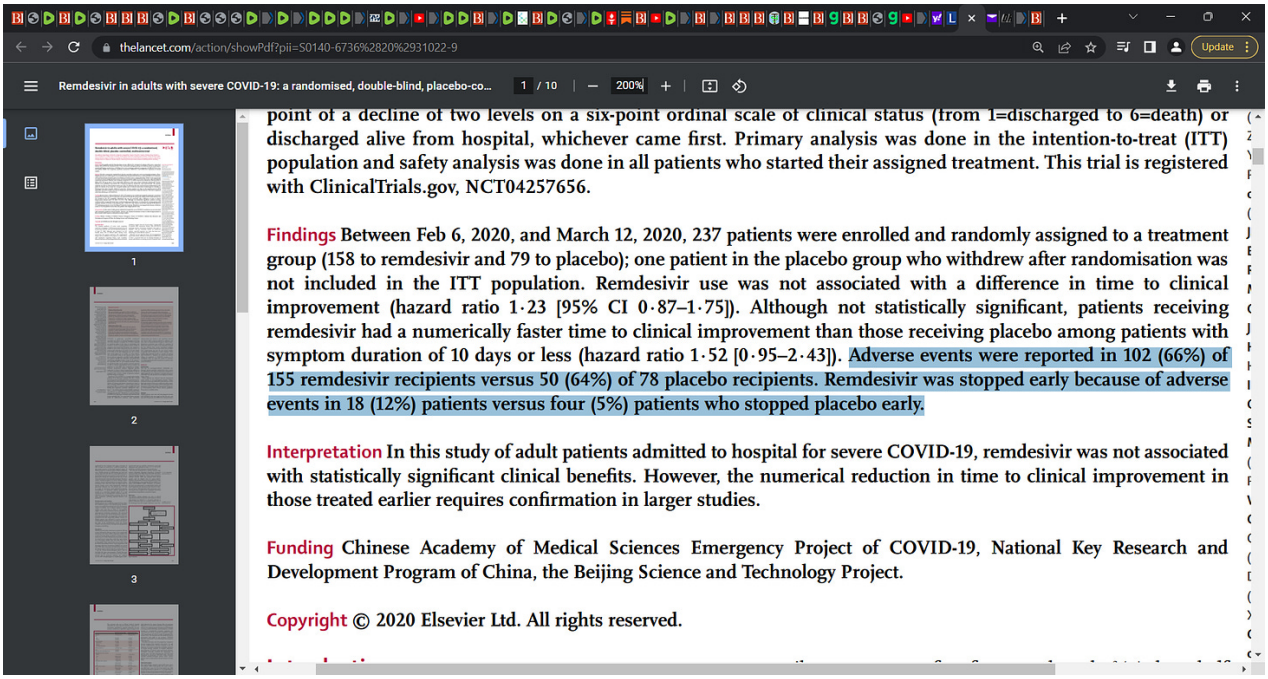
placebo early." In addition, the Kaplan-Meier hazard ratio was not statistically significant, reported as HR 0.73; 95% CI, 0.52 to 1.03 (final report).3

Yet the NIH highly touted and flaunted study that did not report or focus on patient-important objective outcomes and only on reduced time to recovery, was deeply flawed methodologically. The reported primary outcome was time to recovery (discharge from the hospital or hospitalization for infection-control purposes). Why was the reported primary outcome in the NIH study not mortality? Did researchers at NIH (including Dr. Anthony Fauci) use a secondary outcome such as time to recovery as the primary outcome because they were looking at the data and saw no benefit for patient-important outcomes such as mortality?

This is very serious if the NIH researchers tampered with the trial's protocol so that they could declare efficacy yet for a secondary 'less important' outcome. Moreover, the legacy media and the NIH/NIAID officials completely disregarded the key findings (including strong signals of harms) from the LANCET Wang et al. trial released on the very same day. Why? When the glorified NIH study's outcome was not patient-important and there was indication of harms: "serious adverse events were reported in 131 of the 532 patients who received remdesivir (24.6%) and in 163 of the 516 patients who received placebo (31.6%)."

SOURCE: [Wang et al.]



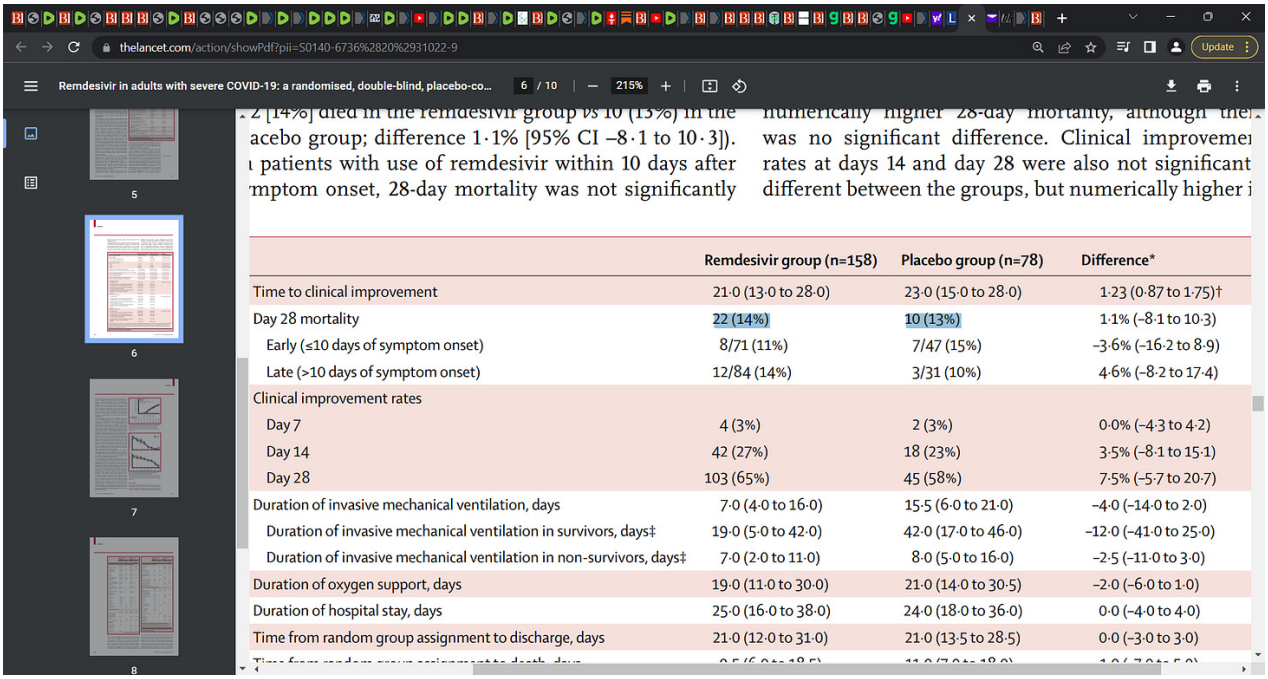


point of a decline of two levels on a six-point ordinal scale of clinical status (from 1=discharged to 6=death) or discharged alive from hospital, whichever came first. Primary analysis was done in the intention-to-treat (ITT) population and safety analysis was done in all patients who started their assigned treatment. This trial is registered with ClinicalTrials.gov, NCT04257656.

Findings Between Feb 6, 2020, and March 12, 2020, 237 patients were enrolled and randomly assigned to a treatment group (158 to remdesivir and 79 to placebo); one patient in the placebo group who withdrew after randomisation was not included in the ITT population. Remdesivir use was not associated with a difference in time to clinical improvement (hazard ratio 1·23 [95% CI 0·87–1·75]). Although not statistically significant, patients receiving remdesivir had a numerically faster time to clinical improvement than those receiving placebo among patients with symptom duration of 10 days or less (hazard ratio 1·52 [0·95–2·43]). Adverse events were reported in 102 (66%) of 155 remdesivir recipients versus 50 (64%) of 78 placebo recipients. Remdesivir was stopped early because of adverse events in 18 (12%) patients versus four (5%) patients who stopped placebo early.

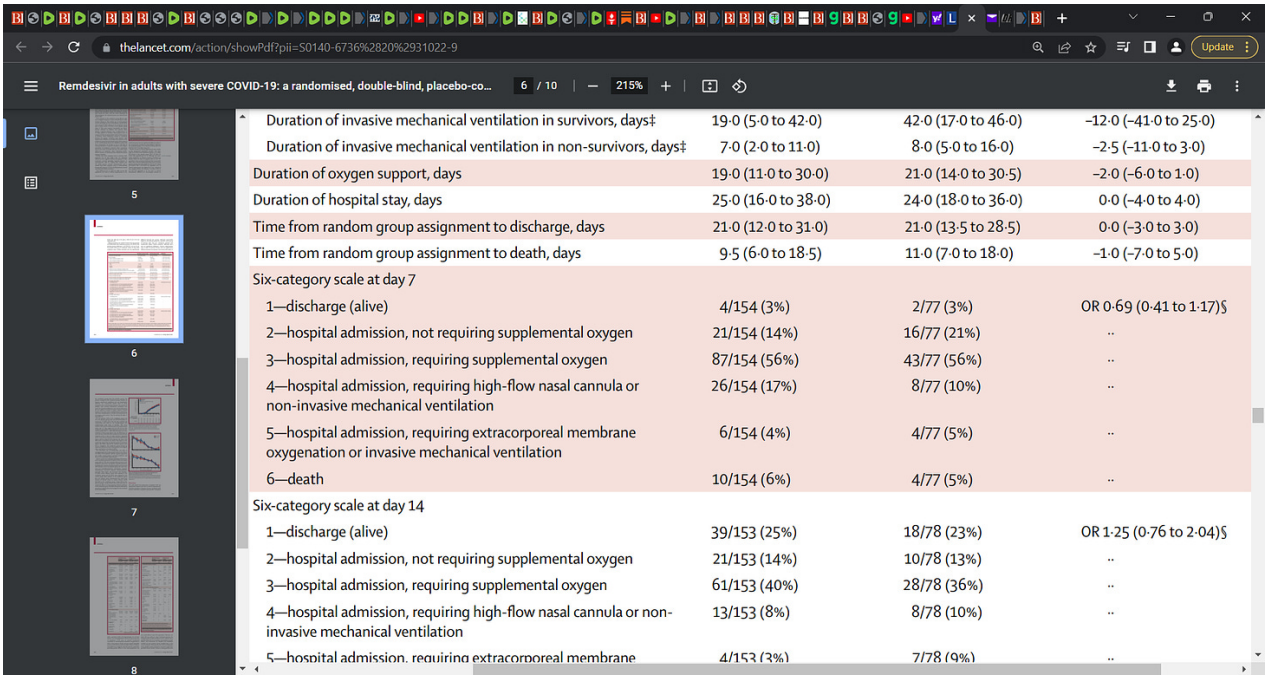
Interpretation In this study of adult patients admitted to hospital for severe COVID-19, remdesivir was not associated with statistically significant clinical benefits. However, the numerical reduction in time to clinical improvement in those treated earlier requires confirmation in larger studies.

Funding Chinese Academy of Medical Sciences Emergency Project of COVID-19, National Key Research and Development Program of China, the Beijing Science and Technology Project.



2 [14%] died in the remdesivir group vs 10 (13%) in the acebo group; difference 1·1% [95% CI −8·1 to 10·3]). ı patients with use of remdesivir within 10 days after mptom onset, 28-day mortality was not significantly numerically higher 28-day mortality, although ther was no significant difference. Clinical improvemer rates at days 14 and day 28 were also not significant different between the groups, but numerically higher i

	Remdesivir group (n=158)	Placebo group (n=78)	Difference*
Time to clinical improvement	21·0 (13·0 to 28·0)	23·0 (15·0 to 28·0)	1·23 (0·87 to 1·75)†
Day 28 mortality	22 (14%)	10 (13%)	1·1% (−8·1 to 10·3)
Early (≤10 days of symptom onset)	8/71 (11%)	7/47 (15%)	−3·6% (−16·2 to 8·9)
Late (>10 days of symptom onset)	12/84 (14%)	3/31 (10%)	4·6% (−8·2 to 17·4)
Clinical improvement rates			
Day 7	4 (3%)	2 (3%)	0·0% (−4·3 to 4·2)
Day 14	42 (27%)	18 (23%)	3·5% (−8·1 to 15·1)
Day 28	103 (65%)	45 (58%)	7·5% (−5·7 to 20·7)
Duration of invasive mechanical ventilation, days	7·0 (4·0 to 16·0)	15·5 (6·0 to 21·0)	−4·0 (−14·0 to 2·0)
Duration of invasive mechanical ventilation in survivors, days‡	19·0 (5·0 to 42·0)	42·0 (17·0 to 46·0)	−12·0 (−41·0 to 25·0)
Duration of invasive mechanical ventilation in non-survivors, days‡	7·0 (2·0 to 11·0)	8·0 (5·0 to 16·0)	−2·5 (−11·0 to 3·0)
Duration of oxygen support, days	19·0 (11·0 to 30·0)	21·0 (14·0 to 30·5)	−2·0 (−6·0 to 1·0)
Duration of hospital stay, days	25·0 (16·0 to 38·0)	24·0 (18·0 to 36·0)	0·0 (−4·0 to 4·0)
Time from random group assignment to discharge, days	21·0 (12·0 to 31·0)	21·0 (13·5 to 28·5)	0·0 (−3·0 to 3·0)



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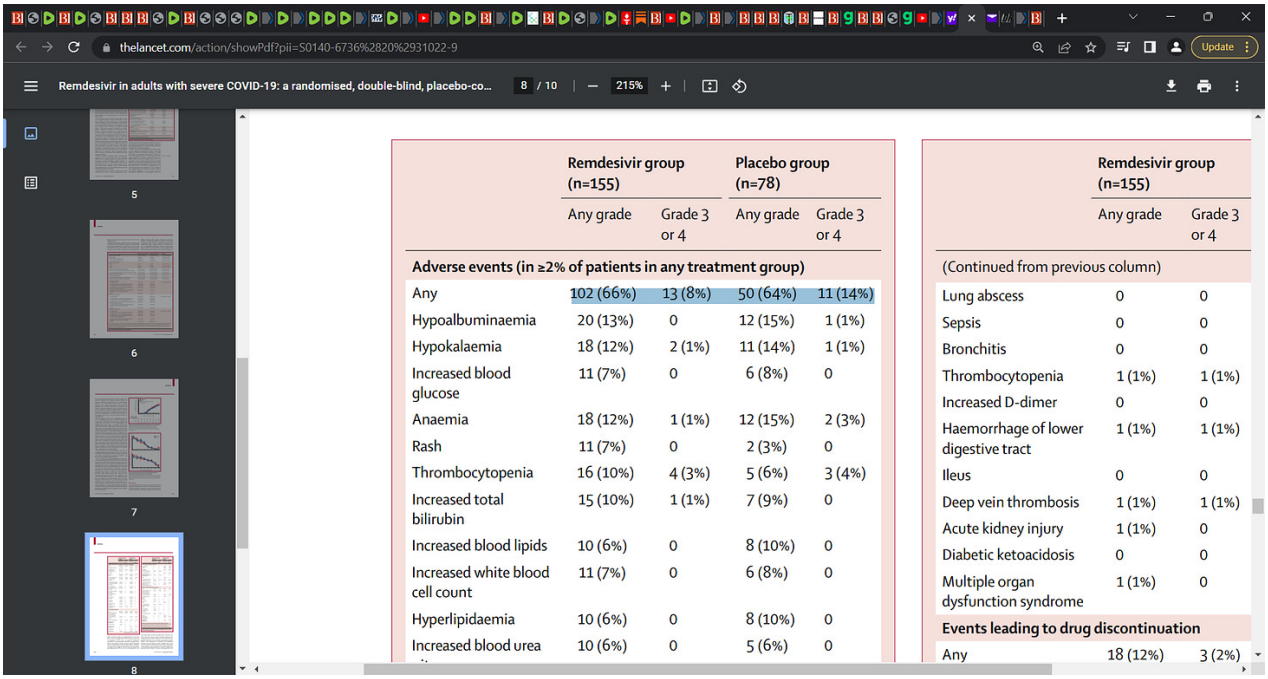
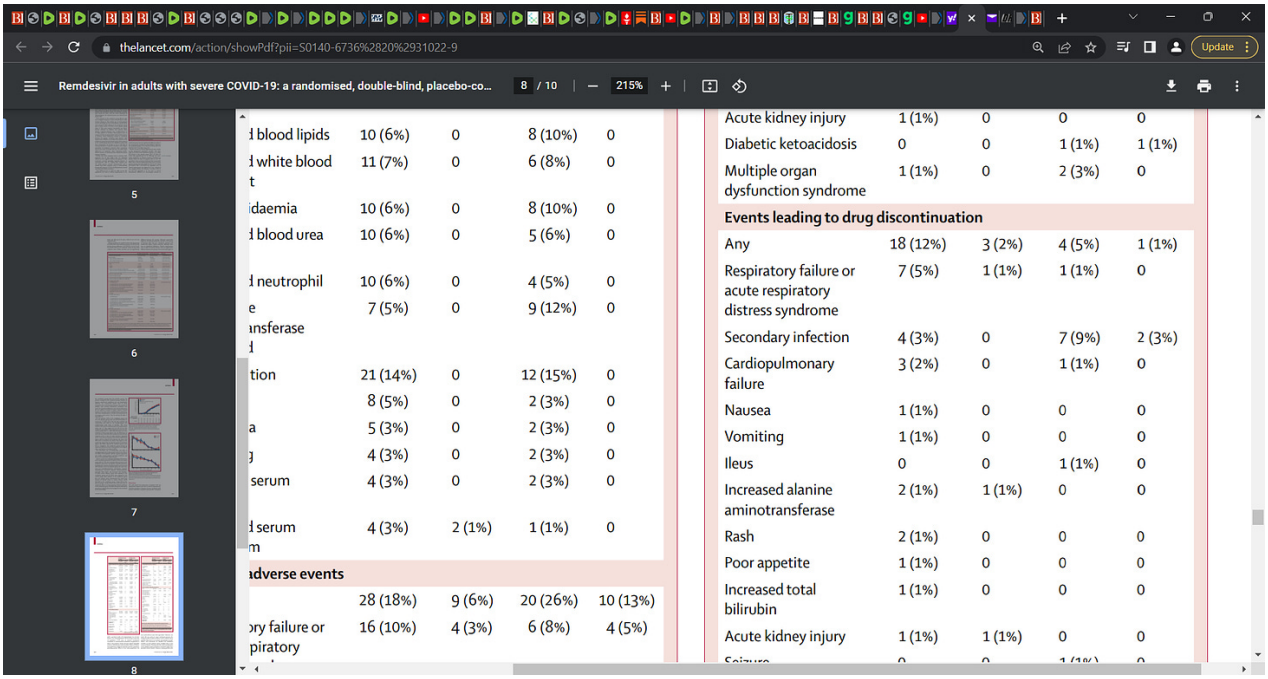
Duration of hospital stay, days	25·0 (16·0 to 38·0)	24·0 (18·0 to 36·0)	0·0 (−4·0 to 4·0)
Time from random group assignment to discharge, days	21·0 (12·0 to 31·0)	21·0 (13·5 to 28·5)	0·0 (−3·0 to 3·0)
Time from random group assignment to death, days	9·5 (6·0 to 18·5)	11·0 (7·0 to 18·0)	−1·0 (−7·0 to 5·0)
Six-category scale at day 7			
1—discharge (alive)	4/154 (3%)	2/77 (3%)	OR 0·69 (0·41 to 1·17)§
2—hospital admission, not requiring supplemental oxygen	21/154 (14%)	16/77 (21%)	..
3—hospital admission, requiring supplemental oxygen	87/154 (56%)	43/77 (56%)	..
4—hospital admission, requiring high-flow nasal cannula or non-invasive mechanical ventilation	26/154 (17%)	8/77 (10%)	..
5—hospital admission, requiring extracorporeal membrane oxygenation or invasive mechanical ventilation	6/154 (4%)	4/77 (5%)	..
6—death	10/154 (6%)	4/77 (5%)	..
Six-category scale at day 14			
1—discharge (alive)	39/153 (25%)	18/78 (23%)	OR 1·25 (0·76 to 2·04)§
2—hospital admission, not requiring supplemental oxygen	21/153 (14%)	10/78 (13%)	..
3—hospital admission, requiring supplemental oxygen	61/153 (40%)	28/78 (36%)	..
4—hospital admission, requiring high-flow nasal cannula or non-invasive mechanical ventilation	13/153 (8%)	8/78 (10%)	..
5—hospital admission, requiring extracorporeal membrane	4/153 (3%)	7/78 (9%)	..

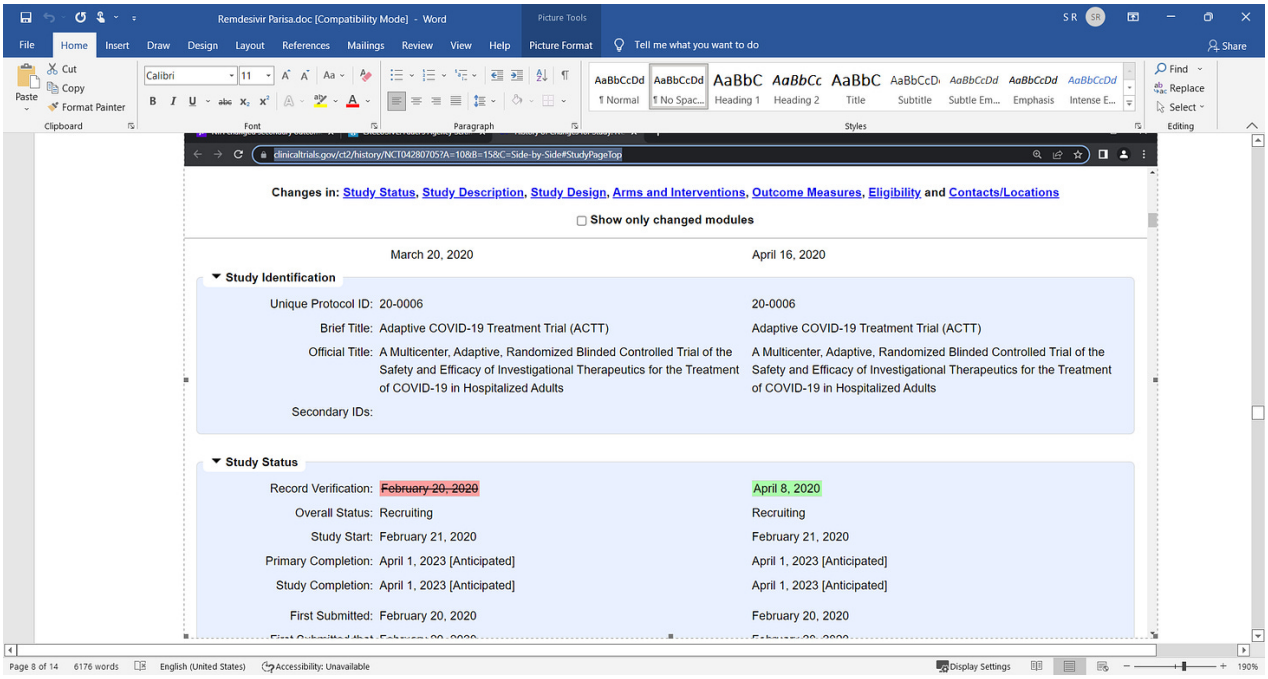


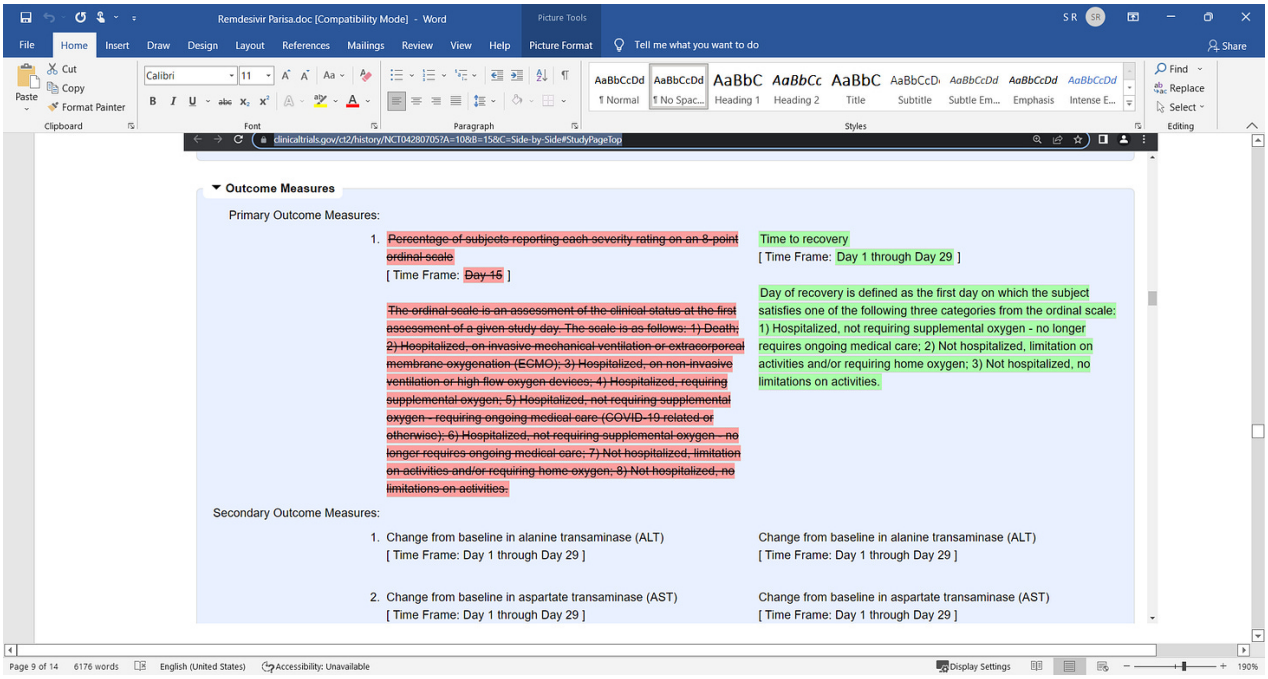
	Remdesivir group (n=155)		Placebo group (n=78)	
	Any grade	Grade 3 or 4	Any grade	Grade 3 or 4
Adverse events (in ≥2% of patients in any treatment group)				
Any	102 (66%)	13 (8%)	50 (64%)	11 (14%)
Hypoalbuminaemia	20 (13%)	0	12 (15%)	1 (1%)
Hypokalaemia	18 (12%)	2 (1%)	11 (14%)	1 (1%)
Increased blood glucose	11 (7%)	0	6 (8%)	0
Anaemia	18 (12%)	1 (1%)	12 (15%)	2 (3%)
Rash	11 (7%)	0	2 (3%)	0
Thrombocytopenia	16 (10%)	4 (3%)	5 (6%)	3 (4%)
Increased total bilirubin	15 (10%)	1 (1%)	7 (9%)	0
Increased blood lipids	10 (6%)	0	8 (10%)	0
Increased white blood cell count	11 (7%)	0	6 (8%)	0
Hyperlipidaemia	10 (6%)	0	8 (10%)	0
Increased blood urea	10 (6%)	0	5 (6%)	0

	Remdesivir group (n=155)	
	Any grade	Grade 3 or 4
(Continued from previous column)		
Lung abscess	0	0
Sepsis	0	0
Bronchitis	0	0
Thrombocytopenia	1 (1%)	1 (1%)
Increased D-dimer	0	0
Haemorrhage of lower digestive tract	1 (1%)	1 (1%)
Ileus	0	0
Deep vein thrombosis	1 (1%)	1 (1%)
Acute kidney injury	1 (1%)	0
Diabetic ketoacidosis	0	0
Multiple organ dysfunction syndrome	1 (1%)	0
Events leading to drug discontinuation		
Any	18 (12%)	3 (2%)



NIH tampered with the protocol:





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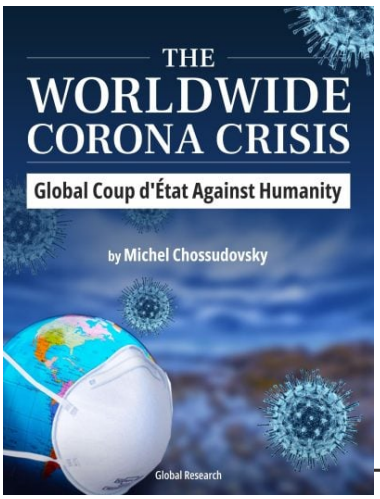

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