Association between convalescent plasma and the risk of mortality among patients with COVID-19: a meta-analysis


1Division of Hematology and Oncology, Department of Internal Medicine, Faculty of Medicine, Universitas Brawijaya, Malang, 65145, Indonesia
2Brawijaya Internal Medicine Research Center, Department of Internal Medicine, Faculty of Medicine, Universitas Brawijaya, Malang, 65145, Indonesia
3Department of Pulmonology and Respiratory Medicine, Faculty of Medicine, Universitas Airlangga, Surabaya, 60286, Indonesia
4Division of Allergy & Immunology, Department of Internal Medicine, Faculty of Medicine, Universitas Airlangga, Surabaya, 60286, Indonesia
5Faculty of Medicine, Universitas Brawijaya, Malang, 65145, Indonesia
6Faculty of Medicine, Universitas Indonesia, Jakarta, 10430, Indonesia
7Department of Biomedical Sciences, Faculty of Medicine, Universitas Brawijaya, Malang, 65145, Indonesia
8Department of Midwifery, Faculty of Medicine, University Brawijaya, Malang, 65145, Indonesia
9Department of Nursing, Faculty of Medicine, Universitas Brawijaya, Malang, 65145, Indonesia
10Department of Neurosurgery, Faculty of Medicine, Universitas Airlangga, Surabaya, 60286, Indonesia
11Department of Radiology, Faculty of Medicine, Universitas Brawijaya, Malang, 65145, Indonesia
12Medical Research Unit, School of Medicine, Universitas Syiah Kuala, Banda Aceh, 23111, Indonesia

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Abstract

Background: Convalescent plasma (CCP) has been used for treating some infectious diseases; however, the efficacy of CCP in coronavirus disease 2019 (COVID-19) remains controversial. The aim of this
research was to assess the efficacy of CCP as an adjunctive treatment in COVID-19 patients.

**Methods:** Embase, PubMed, Web of Science, Cochrane and MedRix were searched for potentially relevant articles. All included papers were assessed for the quality using modified Jadad scale and Newcastle-Ottawa scale for randomized controlled trial (RCT) and non-RCT, respectively. We used a Q test and Egger test to assess the heterogeneity and publication bias among studies, respectively. Mortality rates between patients treated with standard treatment and standard treatment with CCP were compared using a Z test.

**Results:** A total of 12 papers consisting of three cross-sectional studies, one prospective study, five retrospective studies, and three RCT studies were included in our analysis. Of them, a total of 1,937 patients treated with CCP and 3,405 patients without CCP were included. The risk of mortality was 1.92-fold higher in patients without CCP compared to patients treated with CCP (OR: 1.92; 95%CI: 1.33, 2.77; p=0.0005). In severe COVID-19 sub-group analysis, we found that patients without CCP had a 1.32 times higher risk of mortality than those treated with CCP (OR: 1.32; 95%CI: 1.09, 1.60; p=0.0040).

**Conclusions:** CCP, as adjunctive therapy, could reduce the mortality rate among COVID-19 patients.

**Keywords**
convalescent plasma, passive immunization, COVID-19, mortality, outcomes

This article is included in the Disease Outbreaks gateway.

This article is included in the Coronavirus collection.
**Introduction**

The management of coronavirus disease 2019 (COVID-19) remains challenging. While the guideline for the management of COVID-19 has been established, some reports still reported high mortality rate among COVID-19 patients. The guideline suggests that several treatments, including antiviral, hydroxychloroquine, steroid, anticoagulation, and other supportive treatments, should be used to treat patients with COVID-19. However, recent evidence from large scale studies failed to clarify the efficacy of those suggested treatments. Moreover, the findings from the World Health Organization (WHO) solidarity trials also failed to clarify the benefits of hydroxychloroquine, remdesivir, interferon, and lopinavir in the management of COVID-19. Therefore, new approaches to COVID-19 management are required.

Convalescent plasma (CCP), an immunological therapy, is suggested to have promising efficacy for managing several infectious diseases. CCP, a strategy of passive immunization, was first introduced by von Behring and Kitasato in 1890. Initially, it was used to treat diphtheria and other infectious diseases such as scarlet fever and pertussis. Moreover, due to its good efficacy, this therapy was also used for the management of Ebola, severe acute respiratory syndrome (SARS), and Middle East respiratory syndrome (MERS). In patients with MERS, SARS, and Ebola, the clinical improvement and reduced mortality rate were observed in patients receiving CCP compared to patients without CPP. However, the efficacy of CCP against COVID-19 is conflicting. Furthermore, the previous meta-analyses resulted in inconclusive findings due to the lack of structured methodology. Therefore, a holistic meta-analysis is needed to provide insight into the clinical efficacy of CCP for the management of COVID-19.

**Methods**

**Study design**

A systematic review and meta-analysis covering the period July 2020 - December 2020 was conducted to assess the efficacy of CCP as an adjunctive treatment in COVID-19 patients. Studies from prominent bibliographic databases were searched, and the protocols followed the guideline from Preferred Reporting Items for Systematic Review and Meta-analysis (PRISMA).

**Eligibility criteria**

Relevant articles were assessed for inclusion and exclusion criteria before the final analysis. Our analysis included articles with the following criteria: (1) observational or randomized controlled trial studies; (2) providing sufficient data of COVID-19 diagnosis methods; and (3) well-identified methodologies represented with Newcastle-Ottawa Scale (NOS). Case reports, case series, letters to the editor, reviews, commentaries, low method quality, and those with pre-post test comparison were excluded.

**Search strategy and data extraction**

Relevant studies in four bibliographic databases (Embase, PubMed, Web of Science, and Cochrane) and a preprint database MedRix were searched as of 2 December 2020. The searches limited to English only using Medical Subjects Heading: (“COVID-19” OR “SARS-CoV-2”) AND (“convalescent plasma” OR “serotherapy” OR “hyperimmune globulin therapy” OR “convalescent plasma treatment”). A reference list of the relevant articles was also retrieved for additional references. If a duplicate publication was found, the article with the larger sample size was included. Information of: (1) name of the first author; (2) year of publication; (3) country of origin; (4) sample size of cases and controls; (5) CCP administration, and (6) mortality rate were collected from each article. Search strategy and data extraction were conducted by three independent investigators (MI, AAA & YP) using a pilot form. Disagreements were resolved in group discussions through a consensus approach. Before collecting the data, the investigators performed a discussion to define the study variables and the study protocols, and the understanding among the investigators was assessed using kappa test.
Assessment of the methodology quality
All included papers were assessed for the quality using modified Jadad scale for randomized controlled trial (RCT) and Newcastle-Ottawa scale for non-RCT. The quality of the articles was classified as low, moderate, and high quality. Articles with low quality were excluded from our analysis. The assessment was carried out by three independent investigators (MI, AAA & YP), and when there was a discrepancy among the investigators, a discussion was performed with a senior researcher (JKF).

Outcome measure
The primary outcome measure was all causes of mortality among COVID-19 patients treated with and without CCP. The predictor variable was COVID-19 patients treated with CCP. A sub-group analysis was conducted based on the severity of COVID-19 patients treated with CCP (i.e. mild and severe).

Statistical analysis
The association between CCP and the reduction of the risk of mortality among COVID-19 patients was assessed using a Z test. Before assessing the association, the potency of bias and heterogeneity was assessed. To assess the risk of bias, an Egger test was employed to calculate tau-squared, and a p-value of less than 0.05 indicates that the potency of bias was found. A Q test was used to assess the heterogeneity among the included papers. The p-value of less than 0.10 was considered that heterogeneity across the studies was found, and the correlation was therefore determined using a random-effect model; otherwise, a fixed-effect model was employed. All analyses were carried out using Review Manager (Revman Cochrane, London, UK) version 5.3, and the cumulative calculation was presented using a forest plot.

Results
Studies selection and baseline characteristics of the studies
A total of 1,143 papers were identified, and 1,105 papers were excluded because they had irrelevant topics. A total of 38 papers were included for review in full-text, and 26 additional papers were excluded because of review, pre-post test model, commentary, and low-quality papers. In the final process, 12 papers were included in our analysis, consisting of three cross-sectional studies, one prospective study, five retrospective studies, and three RCT studies. The article selection flowchart is depicted in Figure 1, and the study characteristics are presented in Table 1.

CCP efficacy against COVID-19
A total of 1,937 patients treated with CCP and 3,405 patients without CCP, collected from 12 papers, were included in our analysis. Data suggest that COVID-19 patients without the CCP had a 1.92-fold higher risk of mortality than patients treated with the CCP (OR: 1.92; 95%CI: 1.33, 2.77; p = 0.0005) (Figure 2A). A sub-group analysis among severe COVID-19 patients who were treated with CCP was conducted. This sub-group consisted of nine papers with 1,458 patients treated with CCP and 2,706 patients without CCP. The data revealed a 1.32-fold higher risk of mortality in COVID-19 patients without CCP compared to patients treated with CCP (OR: 1.32; 95%CI: 1.09, 1.60; p=0.0040) (Figure 2B).

Heterogeneity and potency of bias across the studies
The analysis revealed evidence of heterogeneity in total case of COVID-19. Therefore, a random-effect model was applied to assess the association between CCP and the risk of mortality among COVID-19 patients. In the severe COVID-19 sub-group, we found no heterogeneity, and we used a fixed-effect model to evaluate the correlation. Our analysis using an Egger test found no publication bias in both the total and the severe COVID-19 sub-group (Funnelplot is provided in supplementary file).

Discussion
Our data suggest that CCP treatment associated with a reduction of mortality both in all cases and severe COVID-19 patients. Our current findings are consistent with the results of previous meta-analyses. The theory underlying the mechanism of CCP in COVID-19 patients remains open to controversy. Briefly, plasma transfer is the potential aspect that bridges the CCP and the reduced risk of mortality in COVID-19 patients. Plasma consists of various immunity components, including antibodies, anti-inflammatory cytokines, clotting and or anti-clotting factors, albumin, and protein C and S. It is believed that CCP in COVID-19 may modulate the immune response through antiviral effects and has immunomodulatory effects. Antiviral effects of CCP may occur through neutralizing antibodies, and it was reported that IgG and IgM anti-severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) were the primary isotype antibodies identified from COVID-19 patients treated with CCP. This humoral immune response may inhibit protein S of SARS-CoV-2. Therefore, they may exert the protective effects against COVID-19. The immunomodulatory effects of CCP may occur through the neutralization of cytokines and complements. These effects may inhibit the overactive immune system, including cytokine storm, complement activation, and hypercoagulable state regulation. These mechanisms may be responsible for causing clinical improvement of COVID-19 patients. Of them, it was considered that immunoglobulin transfer is the essential factor in
modulating the protective effect of CCP. In SARS and influenza, it was reported that immunoglobulin transfer plays a vital role in governing clinical improvement. Moreover, in MERS, the CCP administration with the titers of antibodies 1:80 provided a significant immune response, and the titers of antibodies 1:40 did not provide a similar response. Additionally, in Ebola, MERS, and SARS, the antibodies from the CCP may bind to the CD4 binding site on the viral envelope, and therefore may reduce the viral load and the risk of infection of the new cells. It was also supported by previous studies that antibody titers from CCP donors also governed the clinical improvement of COVID-19 patients treated with CCP, suggesting that antibody transfer might influence the outcomes of clinical improvement.

Six systematic-reviews assessing the role of CCP in COVID-19 have been reported (Table 2). However, they had some significant limitations: (a) the systematic reviews involved had a small sample size while in our current study, we had a relatively larger sample size; (b) some studies did not perform meta-analysis calculations to synthesize the data; (c) some studies included several case reports and case series in which should be excluded in the meta-analysis; (d) previous meta-analyses assessed the role of CCP in similar infectious diseases (SARS and influenza), and the results were implemented to the case of COVID-19; and (e) previous meta-analyses performed a mixed calculation where the data of the case vs. control model were combined with the data of pre-post intervention models, which might provide a high risk of bias due to the final effect that might be caused by other interventions. In the present meta-analysis, we only calculated the model of the case (standard treatment and CCP) vs. control (standard treatment only) and therefore might provide a better correlation.

In the present study, we emphasized that CCP provided good efficacy to reduce the risk of mortality among COVID-19 patients. Our findings might contribute to better management of COVID-19 patients, particularly to prevent the risk of mortality. It is expected that a medical council should elaborate on the standard procedures of CCP, including the dosage, donor criteria, side effects management, and post-intervention management. Since early administration of CCP provided

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**Figure 1. A flowchart of study selection in our meta-analysis.**

Records identified through database searching (n = 1,117)

Additional records identified through other sources (n = 26)

Records after duplicates removed (n = 1,143)

Records screened (n = 38)

Records excluded (n = 1,105)

Full-text articles excluded with reasons: review (n = 6), commentary (n = 11), inadequate data (n = 6), poor quality (n = 3)

Studies included in qualitative synthesis (n = 12)

Studies included in quantitative synthesis (meta-analysis) (n = 12)
Table 1. Baseline characteristics of articles included in our meta-analysis.

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Study design</th>
<th>City</th>
<th>Sample size</th>
<th>CCP</th>
<th>Control</th>
<th>CCP volume</th>
<th>Recipient</th>
<th>Quality assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abolghassemi et al 2020</td>
<td>Iran</td>
<td>Cross-sectional</td>
<td>Mixed</td>
<td>115</td>
<td>74</td>
<td>500 mL</td>
<td>500 mL</td>
<td>Mild and severe cases</td>
<td>High</td>
</tr>
<tr>
<td>Altuntas et al 2020</td>
<td>Turkey</td>
<td>Retrospective</td>
<td>Mixed</td>
<td>888</td>
<td>888</td>
<td>200-600 mL</td>
<td>200-600 mL</td>
<td>Severe cases</td>
<td>High</td>
</tr>
<tr>
<td>Chen et al 2020</td>
<td>China</td>
<td>Retrospective</td>
<td>Hangzhou</td>
<td>19</td>
<td>10</td>
<td>200-500 mL</td>
<td>200-500 mL</td>
<td>Severe cases</td>
<td>Moderate</td>
</tr>
<tr>
<td>Gharbharan et al 2020</td>
<td>Netherlands</td>
<td>RCT</td>
<td>Mixed</td>
<td>43</td>
<td>43</td>
<td>300 mL</td>
<td>300 mL</td>
<td>Mild and severe cases</td>
<td>Moderate</td>
</tr>
<tr>
<td>Hegerova et al 2020</td>
<td>USA</td>
<td>Retrospective</td>
<td>Washington</td>
<td>20</td>
<td>20</td>
<td>200 mL</td>
<td>200 mL</td>
<td>Severe cases</td>
<td>High</td>
</tr>
<tr>
<td>Li et al 2020</td>
<td>China</td>
<td>RCT</td>
<td>Wuhan</td>
<td>52</td>
<td>51</td>
<td>100 mL</td>
<td>100 mL</td>
<td>Severe cases</td>
<td>Moderate</td>
</tr>
<tr>
<td>Rasheed et al 2020</td>
<td>Iraq</td>
<td>Cross-sectional</td>
<td>Bagdad</td>
<td>21</td>
<td>28</td>
<td>400 mL</td>
<td>400 mL</td>
<td>Severe cases</td>
<td>High</td>
</tr>
<tr>
<td>Salazar et al 2020 (a)</td>
<td>US</td>
<td>Cross-sectional</td>
<td>Mixed</td>
<td>321</td>
<td>582</td>
<td>NA</td>
<td>NA</td>
<td>Mild and severe cases</td>
<td>High</td>
</tr>
<tr>
<td>Salazar et al 2020 (b)</td>
<td>US</td>
<td>Prospective</td>
<td>Mixed</td>
<td>85</td>
<td>158</td>
<td>NA</td>
<td>NA</td>
<td>Severe cases</td>
<td>High</td>
</tr>
<tr>
<td>Xia et al 2020</td>
<td>China</td>
<td>Retrospective</td>
<td>Wuhan</td>
<td>138</td>
<td>1430</td>
<td>200-1200 mL</td>
<td>200-1200 mL</td>
<td>Severe cases</td>
<td>High</td>
</tr>
<tr>
<td>Zeng et al 2020</td>
<td>China</td>
<td>Retrospective</td>
<td>Hangzhou</td>
<td>6</td>
<td>15</td>
<td>300 mL</td>
<td>300 mL</td>
<td>Severe cases</td>
<td>High</td>
</tr>
</tbody>
</table>

Note: CCP, convalescent plasma; NOS, Newcastle-ottawa scale.
Table 2. Previous systematic review and meta-analyses and some potential limitations.

<table>
<thead>
<tr>
<th>Author &amp; year</th>
<th>Number of studies</th>
<th>Sample size</th>
<th>Potential limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bakhtawar et al 2020</td>
<td>10</td>
<td>156</td>
<td>- No calculation of data synthesis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Seven case report or case series articles were included</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- One study comparing the outcome between pre and post convalescent plasma.</td>
</tr>
<tr>
<td>Devasenapathy et al 2020</td>
<td>6</td>
<td>431</td>
<td>- The case is non COVID-19</td>
</tr>
<tr>
<td>Rabelo-da-Ponte et al 2020</td>
<td>5</td>
<td>75</td>
<td>- Three case report or case series articles were included</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- The comparison was pre and post convalescent plasma.</td>
</tr>
<tr>
<td>Rajendran et al 2020</td>
<td>5</td>
<td>NA</td>
<td>- No calculation of data synthesis</td>
</tr>
<tr>
<td>Sarkar et al 2020</td>
<td>7</td>
<td>5444</td>
<td>- One study comparing the outcome between pre and post convalescent plasma, other studies assessing between convalescent plasma and control (Mixed calculation).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Inappropriate calculation.</td>
</tr>
<tr>
<td>Sun et al 2020</td>
<td>15</td>
<td>1879</td>
<td>- The case is non COVID-19</td>
</tr>
</tbody>
</table>

Note: NA, Not available; CCP, convalescent plasma.
better clinical outcomes than those with later intervention, the appropriate time of CCP administration should be determined, and further studies are warranted.

Several important limitations of this study should be discussed. Some confounding factors that might govern the final outcomes were not controlled, including the immunological status, the dosage of CCP, time of intervention, donor criteria, the titers of antibodies, comorbidities, and transmission area. The majority of the included papers were retrospective studies, and therefore a further meta-analysis of randomized-controlled trials with a bigger sample size might provide a better conclusion.

**Conclusion**
Administration of the CCP is associated with a lower risk of mortality among COVID-19 patients compared to those without CCP, and this highlights its potency to be used for the treatment of COVID-19. However, studies are warranted to formulate the dosage, time of intervention, donor criteria, and the titers of antibodies to optimize the effects.

**Data availability**
Underlying data
All data underlying the results are available as part of the article and no additional source data are required.

**Reporting guidelines**

**Extended data**
The supplementary file regarding the funnel plot of our study is provided in Figsshare (https://doi.org/10.6084/m9.figshare.14046254.v1).

Data are available under the terms of the Creative Commons Attribution 4.0 International license (CC-BY 4.0).

**Acknowledgements**
We thank to Lembaga Pengelola Dana Pendidikan (LPDP) Republik Indonesia for supporting this project.

**References**
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PubMed Abstract | Publisher Full Text

PubMed Abstract | Publisher Full Text | Free Full Text

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Publisher Full Text

Publisher Full Text
Guilherme Welter Wendt
Health Sciences Center, Western Paraná State University (UNIOESTE), Francisco Beltrão, Brazil

After reading the revised version of the paper, I can see that authors addressed the previous suggestions and their manuscript seems suitable for approval.

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Quantitative research methods; systematic reviews; meta-analyses

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

The study sought to assess the efficacy of CCP as an adjunctive treatment in COVID-19 patients. The authors are encouraged to:

1. Correctly report the names of the instruments used (Newcastle-Ottawa, and not Newcaste-
2. There are two dots in the end of the second sentence of the results section in the abstract.

3. In the introduction, the following sentence could be expanded: “the mortality rate of COVID-19 remains increased over the periods”. Please, focus on the literature you cited and be specific as possible. For instance, some reports show the opposite, that is, that treatment has improved so the mortality rate has decreased. The authors’ very own findings point to lower OR for death among those treated with CCP.

4. Albeit it is true that the solidarity trial showed little efficacy of the drugs mentioned in the introduction, a robust finding was found in severe patients that were treated with dexamethasone.

5. Would you please give more information on clinical improvement of the diseases treated with CCP cited in the second paragraph (introduction, ref. n. 12)?

6. The following sentence needs a few supporting references: “However, the efficacy of CCP against COVID-19 is conflicting”.

7. I would suggest the authors to remove the word “holistic” when presenting their goal.

8. When presenting the eligibility criteria, I was wondering why pre-post comparisons were excluded. Would be worth it to justify this choice.

9. I would change this sentence “If the disagreement was found, we performed a discussion to resolve the disagreement” into “Disagreements were resolved in group discussions”. Also, did you ask for an external judge to assist in the discussion of disagreements? Or a consensus approach was used? This is unclear.

10. There is a typo in the section describing the outcome variable (e.i. mild and severe). Please, correct to “i.e.”; Also, the outcome variables could be more clear. Do you mean “the number or COVID-19 patients treated with CCP”?

11. In the section “Heterogeneity and potency of bias across the studies”, please be clear/complete in the following sentence “a random-effect model was applied to assess the Association...”. Association between what?

12. This sentence needs more information: “In the present meta-analysis, we only calculated the model of the case (standard treatment and CCP) vs. control (standard treatment only) and therefore might provide a better correlation”. Would you please justify why your approach provides better ‘correlation’?

13. Please, double check the comprehensiveness of Table 2. The table is supposed to present previous meta-analyses and some of the studies included there were judged to not calculate data synthesis. However, I see that some studies are only systematic reviews, such as Rajendran and collaborators.

15. The supplementary Prisma checklist contains information not covered in the study. For instance, the authors said that the systematic review registration number has been given in the abstract, albeit I was not able to find it. This checklist also asks the authors to be explicit about the language of papers under “eligibility”. This should be made clear in the text and in the supplementary checklist. Item 19 of the same checklist asks that authors “present data on risk of bias of each study”. I could not locate this in the text. Please, revise this item.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
No source data required

Are the conclusions drawn adequately supported by the results?
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Quantitative research methods; systematic reviews; meta-analyses

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 06 Apr 2021

**Jonny Fajar**, Universitas Brawijaya, Malang, Indonesia

**Response to reviewer comments:**
The study sought to assess the efficacy of CCP as an adjunctive treatment in COVID-19 patients. The authors are encouraged to:

Correctly report the names of the instruments used (Newcastle-Ottawa, and not Newcastle-ottawa; Jadad scale, and not jadad) in the whole text, including the abstract.
Response: The phrase has been revised.

There are two dots in the end of the second sentence of the results section in the abstract.  
Response: We have revised the sentence.

In the introduction, the following sentence could be expanded: “the mortality rate of COVID-19 remains increased over the periods”. Please, focus on the literature you cited and be specific as possible. For instance, some reports show the opposite, that is, that treatment has improved so the mortality rate has decreased. The authors’ very own findings point to lower OR for death among those treated with CCP.  
Response: The sentence has been revised.

Albeit it is true that the solidarity trial showed little efficacy of the drugs mentioned in the introduction, a robust finding was found in severe patients that were treated with dexamethasone.  
Response: We only reported the findings of the trial. The trial did not include dexamethasone.

Would you please give more information on clinical improvement of the diseases treated with CCP cited in the second paragraph (introduction, ref. n. 12)?  
Response: The clinical improvement indicated the improvement of disease manifestation.

The following sentence needs a few supporting references: “However, the efficacy of CCP against COVID-19 is conflicting”.  
Response: In this sentence, we tried to explained that, among all included studies in our analysis, some studies found the efficacy of CCP for treating COVID-19, while other studies failed to clarify the efficacy. The references were provided in the results section.

I would suggest the authors to remove the word “holistic” when presenting their goal.  
Response: the word “holistic” has been removed.

When presenting the eligibility criteria, I was wondering why pre-post comparisons were excluded. Would be worth it to justify this choice.  
Response: The reason why pre-post comparisons were excluded from our study is we considered that the outcomes of therapy might have high risk of bias due to the final outcomes were affected by CCP or other medications.

I would change this sentence “If the disagreement was found, we performed a discussion to resolve the disagreement” into “Disagreements were resolved in group discussions”. Also, did you ask for an external judge to assist in the discussion of disagreements? Or a consensus approach was used? This is unclear.  
Response: The sentence has been revised.

There is a typo in the section describing the outcome variable (e.i. mild and severe). Please, correct to “i.e.”; Also, the outcome variables could be more clear. Do you mean “the number or COVID-19 patients treated with CCP”?  
Response: The sentence has been revised.
In the section “Heterogeneity and potency of bias across the studies”, please be
clear/complete in the following sentence “a random-effect model was applied to assess the
Association...”.

Response: The sentence has been revised.

This sentence needs more information: “In the present meta-analysis, we only calculated
the model of the case (standard treatment and CCP) vs. control (standard treatment only)
and therefore might provide a better correlation”. Would you please justify why your
approach provides better ‘correlation’?

Response: We considered that the design of standard treatment and CCP vs. standard
treatment only, and the patients were followed up after the periods might have better
efficacy than the design of pre-post comparisons. In the design of pre-post comparisons,
the outcomes of therapy might have high risk of bias due to the final outcomes were
affected by CCP or other medications.

Please, double check the comprehensiveness of Table 2. The table is supposed to present
previous meta-analyses and some of the studies included there were judged to not
calculate data synthesis. However, I see that some studies are only systematic reviews, such
as Rajendran and collaborators.

Response: The sentence has been revised.

Supplementary file 2 has some typos
including “Funnel plot of the association”. Would you please correct it?

Response: The supplementary file 2 has been revised.

The supplementary Prisma checklist contains information not covered in the study. For
instance, the authors said that the systematic review registration number has been given in
the abstract, albeit I was not able to find it. This checklist also asks the authors to be explicit
about the language of papers under “eligibility”. This should be made clear in the text and in
the supplementary checklist. Item 19 of the same checklist asks that authors “present data
on risk of bias of each study”. I could not locate this in the text. Please, revise this item.

Response: The study registration is on process. The risk of bias was assessed using Egger
test. The quality of each study was assessed using Newcastle-ottawa scale and Modified
Jadad scale.

Competing Interests: We have no competing interest
Morteza Arab-Zozani
Social Determinants of Health Research Center, Birjand University of Medical Sciences, Birjand, Iran

Thank you for clearly addressing my previous comments. In my opinion, the manuscript is acceptable in this way.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Health-related issues and systematic review and meta-analysis methodology.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 1

Reviewer Report 15 February 2021

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Iran

This meta-analysis aimed to investigate the association between convalescent plasma and the risk of mortality among patients with COVID-19. This is a great area of research but, in my opinion, the manuscript needs some major revisions as follows:

- Please indicate the name of the searched databases in the abstract section.

- Please indicate the quality appraisal checklist in the abstract section.

- Please indicate the method for investigating the heterogeneity and publication bias in the abstract section.

- Please indicate the type of the included studies in the abstract, results, and table 1.

- What is your reason for selecting this period for your search?

- Search strategy is not complete.

- Please restructure the method section following the PRISMA item as you claim.

- There are some problems regarding figure 1. Was there no duplicate record? It does not make much sense.

- It needs to mention the type of the included studies and then we can speak about the quality appraisal checklist. It seems that NOS is not sufficient. NOS is for nonrandomized studies.

- Please indicate inter-rater reliability between three raters.

- Result section, please add a subheading for "study characteristics" based on PRISMA and first write a brief and then refer to table 1. Also, add the type of the control in column control.

- Figure 1 has some problems. Your study is a meta-analysis. How were 11 studies included in qualitative synthesis? Which qualitative synthesis?

- There is a 6% difference between I² for A and B, what is your rationale for selecting the fixed or random-effect model? Please provide a reference for your claim. Please add the details in the method section.

- Please add the funnel plot as a supplement.

- Please remove table 2 from the discussion and also discuss the added value of your study regarding the existing meta-analysis. What is the novelty of your work?

- The conclusion is very optimistic. How did you come to that conclusion based solely on mortality?
Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

If applicable, is the statistical analysis and its interpretation appropriate?
Partly

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
No

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Health-related issues and systematic review and meta-analysis methodology.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

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