Cameroon Townhall for Healthcare Professionals

Meeting Minutes, September 11, 2021

Host: Cameroon Townhall for Healthcare Professionals

Date: September 11, 2021

Chair: Dr. Munoh Kenne Foma

Co-Moderators: Dr. Bryan Tegomoh, Elvis Ndansi

Guest Speakers: Dr. Munoh Kenne Foma, MD, Chair, Cameroon Town Hall for Healthcare Professionals (presenter for this session); Dr. Boghuma Kabisen Titanji, MD, MSc, DTM&H, PhD, Infectious Diseases Fellow, Emory University School of Medicine, Atlanta (invited panelist)

Title: A Light in the Darkness: Therapies Recently Granted Emergency Use Authorization for COVID-19

Agenda Items:

1. Welcome and opening remarks by the co-moderators, Dr. Bryan Tegomoh and Elvis Ndansi
2. Birthday greetings to the Chair, Dr. Munoh Kenne Foma
3. Presentation by Dr. Munoh Kenne Foma on "A Light in the Darkness: Therapies Recently Granted EUA for COVID-19"
4. Panel contributions by Dr. Boghuma Kabisen Titanji
5. Discussion and Q&A
6. Adjournment, closing points and parking lot

Opening Remarks:

- Dr. Bryan Tegomoh welcomed participants and introduced co-moderator Elvis Ndansi.
- Elvis Ndansi recalled the previous session, in which Dr. Ivo Che Ditah spoke on colorectal cancer screening and the lowering of the recommended screening age to 45.
- The session fell on the Chair's birthday; participants sang for Dr. Foma and posted messages in the chat.

- Elvis Ndansi explained that the town hall was returning to COVID-19, the subject that first brought the group together, this time to focus on therapeutics rather than vaccines, and that the presentation would serve as a baseline for an open exchange.

Presentation Points:

Presentation by Dr. Munoh Kenne Foma: "A Light in the Darkness: Therapies Recently Granted EUA for COVID-19"

1. Pandemic situation and vaccines:

Dr. Foma noted that close to 250 million infections and more than 4.5 million deaths had been recorded worldwide and that about 1.5 billion people had been vaccinated. Cameroon was beginning to see a third wave, with new cases reported from the North West Region. AstraZeneca, Sinopharm and Johnson & Johnson vaccines were available in Cameroon, and he said the problem there was less availability than reluctance to be vaccinated. He cited data that vaccinated people had about one fifth the risk of infection and about one tenth the risk of hospitalisation or death.

2. Variants and the booster question:

The Delta variant was described as far more infectious than the original strain, with an R0 of 5 to 8 against 2 to 2.6. Israel had given booster doses to people over 60 and to health workers and had seen its third wave turn around. Dr. Foma questioned whether falling antibody titres were the right measure of vaccine efficacy, since the immune system also produces memory cells, and asked that CDC analyse breakthrough infections by vaccine type and dosing interval.

3. Two phases of disease, two kinds of treatment:

About 80 percent of infections were asymptomatic or mild and about 6 percent became critical. Dr. Foma explained that COVID-19 has a viral phase, where antivirals and antibody therapies act, and an inflammatory phase, where immune modulators act, and that most therapeutic success had come in the inflammatory phase. A Cameroonian case series showed a pattern similar to China's but with less severe disease, which he linked to the country's young population (median age about 18). Age was the single most important risk factor for severe disease.

4. What did not work:

Hydroxychloroquine, lopinavir and other antiretrovirals, interferon, azithromycin, vitamin C, vitamin D in hospitalised patients, zinc, N-acetylcysteine and BCG were all negative in trials. Dr. Foma did not advise ivermectin where better options exist and

noted that the NIH and IDSA did not recommend it. Colchicine showed a very modest benefit, while fluvoxamine (TOGETHER trial) and molnupiravir were described as promising but awaiting results.

5. Outpatient care: monoclonal antibodies:

For non-hospitalised high-risk patients with symptoms for under 10 days, three monoclonal antibody products held EUAs in the United States: bamlanivimab/etesevimab (Eli Lilly), casirivimab/imdevimab (Regeneron) and sotrovimab (GlaxoSmithKline). Trials showed reductions in progression of roughly 70 to 85 percent, and a new EUA covered post-exposure prophylaxis for high-risk contacts. The Lilly product had been paused in areas where resistant variants exceeded 5 percent. Dexamethasone and remdesivir were contraindicated in outpatients who did not need oxygen. These antibodies were not available in most African countries.

6. Inpatient care: dexamethasone, baricitinib, tocilizumab:

Dexamethasone 6 mg daily for up to 10 days (RECOVERY trial) was recommended only for patients requiring oxygen. Remdesivir reduced length of stay, but Dr. Foma called it a "glorified placebo" on mortality. Baricitinib 4 mg daily for up to 14 days, adjusted for kidney function, reduced length of stay and, in COV-BARRIER, mortality; it could be bought in Cameroon but was expensive, with tofacitinib as an alternative. Tocilizumab, or sarilumab in its absence, held an EUA for ICU patients. He presented two teaching cases: a 29-year-old pregnant woman suitable for monoclonal antibodies, and a 47-year-old kidney transplant recipient on high-flow oxygen suitable for baricitinib.

7. Convalescent plasma and options for Africa:

High-titre convalescent plasma held an EUA and was described as technically feasible in Africa, though of limited efficacy. Dr. Foma concluded that Africa had little that prevented progression to severe disease and called on WHO and others to advocate for access to monoclonal antibodies. He also credited Dr. Titanji for early, accurate calls on steroids, baricitinib and IL-6 inhibitors.

Discussions and Q&A Session:

- **Dr. Ojong, citing magnesium sulfate for eclampsia becoming unavailable in Zimbabwe after a trial proved it worked, asked whether large pharmaceutical companies might be manipulating data against ivermectin because it is cheap.** Dr. Foma noted that the industry had not blocked dexamethasone, which is equally cheap, and called for Cameroonian clinical trials (for example in Bamenda) to settle the question locally. Dr. Titanji added that a fraudulent Egyptian study, since retracted, had skewed the favourable meta-analyses, that four NIH-funded trials

were ongoing, and that mass use in Cameroon carried a risk of fatal reactions where Loa loa circulates. She supported a single dose of ivermectin only for patients from Strongyloides-endemic areas who receive steroids.

- **A participant studying at the Institute of Tropical Medicine in Antwerp asked what to give a COVID-positive patient with mild symptoms.** Dr. Foma said high-risk patients in the US or Europe would receive monoclonal antibodies; in Cameroon, management was close monitoring, nutrition, hygiene and masking, as azithromycin, hydroxychloroquine and doxycycline do not work. Dr. Titanji outlined a Cameroon-adapted pathway: supportive care and self-proning at home, seeking care if oxygen saturation falls below 92 percent, dexamethasone and oxygen once oxygen is needed, then adding oral baricitinib 4 mg (never three immunomodulators together). She noted that tocilizumab requires central venous access, which many hospitals cannot provide.
- **A participant asked whether baricitinib can be used in dialysis patients or below a GFR cutoff.** Dr. Titanji said dialysis patients were excluded from the trials and should receive steroids or IL-6 inhibitors instead; baricitinib can be used down to a GFR of 30, at 2 mg daily for GFR 30 to 60. She preferred it because its 24-hour half-life lets immune suppression stop at discharge, unlike tocilizumab, which persists for weeks. Dr. Foma described treating a child with baricitinib early in the pandemic and avoiding intubation.
- **Dr. Katte Jean-Claude asked about the cost of baricitinib for Cameroon and about anticoagulation, noting that severe patients in Cameroon on heparin bled heavily and that many had taken herbal concoctions. He also asked how the Ministry could approve a traditional remedy without published data.** Dr. Foma estimated US$2,000 to 3,000 per course in the US and criticised approving remedies without trials. Dr. Titanji reported that Eli Lilly had licensed Indian generic manufacturers, bringing 30 tablets of 4 mg to about US$47 (about 20,000 FCFA, or roughly 10,000 FCFA per patient). She said the national guidelines lagged behind WHO guidance and should be updated regularly, and that traditional medicine deserves proper testing.
- **A public health physician in Cameroon asked about the real-world effectiveness of these drugs, noting that COVID-19 cases rose after an ivermectin mass distribution campaign.** Dr. Foma urged field teams to publish comparisons between districts with and without ivermectin distribution. Dr. Titanji said dexamethasone was estimated to have averted about 150,000 deaths in the UK, and that Cameroon was among the ten countries with the lowest vaccine uptake in sub-Saharan Africa (about 0.5 percent of the population), with about 90 percent of hospitalised patients unvaccinated.

- **A doctor in Douala who had received one AstraZeneca dose asked whether Johnson & Johnson could serve as the second dose, and commented that Cameroonian doctors are not trained in evidence-based medicine and that an opportunity to fund COVID-19 research had been missed.** Dr. Titanji said mixing AstraZeneca and mRNA vaccines was well supported, but she would avoid AstraZeneca followed by J&J because both carry a small thrombosis risk, and advised Sinopharm for the second dose. She said vitamins may be given if not presented as a COVID-19 cure, and warned that indirect deaths from disrupted TB, malaria and HIV control make COVID-19 serious in Africa even without visible mass deaths.
- **A participant asked about empiric antifungals such as micafungin in severe COVID-19 and about recognised post-COVID syndromes.** Dr. Titanji advised treating fungal or bacterial superinfection only when culture-proven, as micafungin targets yeasts that do not cause pneumonia. Long COVID had no consensus case definition yet, affected about 5 to 10 percent of survivors, and was less common after vaccination. She advised vaccinating people who had already had COVID-19.
- **Dr. Bryan Tegomoh asked about booster doses in the context of global vaccine inequity, boosters for patients on rituximab, MIS-C in children, paediatric monoclonal antibody trials, and plans to deploy monoclonal antibodies in Africa.** Dr. Titanji supported boosters for people over 60 and for many immunocompromised patients, noting that T-cell responses in rituximab patients were not well characterised. MIS-C had risen with Delta and school reopening. She was not aware of monoclonal antibody trials in children under 12. Dr. Foma said oncology patients on rituximab were being advised to take a third dose.

Call to Action and Closing:

- Dr. Foma called on all participants, including district medical officers, to vaccinate, educate and use every opportunity to generate local data.
- A chat question on procalcitonin was deferred to a future dedicated session.
- Dr. Bryan Tegomoh thanked the panel and participants and closed the session; participants were invited to stay for the parking lot discussion.

Recording: https://www.youtube.com/watch?v=JgE2vpSnx-0

Submitted by: Co-Moderators, Cameroon Townhall for Healthcare Professionals