Appendix 2 (as supplied by the authors): Patient or population: Children or adults with severe COVID-19 infection
Intervention: Convalescent or hyperimmune intravenous immunoglobulin
Comparison: Usual care + placebo (saline or intravenous immunoglobulin)

Outcomes	Relative effects, Source of evidence	Absolute effects		Certainty/Quality of evidence	Plain language summary
		Baseline risk for control group (per 1000)	Difference (95% CI) (per 1000)		
Mortality (7- 28 days)	RR 0.94 (95%CI 0.49 to 1.80) Based on 572 influenza patients in 4 RCTs	104[1]	-6 (-53, 84)	Very Low ⨁⊖ ⊖⊖ (Very serious indirectness and serious imprecision)[2]	Convalescent plasma may have little to no effect on mortality but the evidence is very uncertain
Mortality (22 days)	RR 0.10 (95% CI 0.01 to 1.70) Based on 40 SARS patients in 1 observational study	104[1]	-94 (-103, 73)	Very Low ⨁⊖ ⊖⊖ (Serious indirectness, very serious risk of bias and serious imprecision)[3]	Convalescent plasma could have an important effect on decreasing or increasing mortality but the evidence is very uncertain
Recovery by 28 days as measured by a 6-point ordinal scale[4]	Proportional odds ratio for recovery[4] OR 1.05 (95% CI 0.67 to 1.64) Based on 438 influenza patients from 2 RCTs	104[1]	5, (-30, 56)	Very Low ⨁⊖ ⊖⊖ (Very serious indirectness and serious imprecision)[2]	Convalescent plasma may have little to no effect on recovery but the evidence is very uncertain
Length of hospital stay in days	Based on 259 influenza patients in 3 RCTs	Median 13 days[5]	MD -1.62 (-3.82, 0.58) days	Very Low ⨁⊖ ⊖⊖ (Very serious indirectness and serious imprecision)[2]	Convalescent plasma may confer a small reduction in hospital length of stay but the evidence is very uncertain
Length of ICU stay in days	Based on 149 influenza patients in 2 RCTs	Median 7 days[6]	MD -0.32 (95% CI -3.20 , 2.56)	Very Low ⨁⊖ ⊖⊖ (Very serious indirectness and serious imprecision)[2]	Convalescent plasma may have little to no effect in reducing duration of ICU stay but the evidence is very uncertain

Days on mechanical ventilation	Based on 83 influenza patients in 2 RCTs	Median 9.25 days[6]	MD -3.67 (95% CI -7.70, 0.36)	Very Low ⨁⊖ ⊖⊖ (Very serious indirectness and serious imprecision)[2]	Convalescent plasma may reduce days of mechanical ventilation but the evidence is very uncertain
Serious adverse events	RR 0.85 (95% CI 0.56, 1.29) Based on 576 patients with influenza in 3 RCTs	80[7]	-12 (-35, 23)	Low ⨁⨁⊖⊖ (Serious indirectness and imprecision)[8]	Convalescent plasma may result in little or no difference in number of serious adverse events.

RCT: randomized controlled trials; ICU: Intensive care unit; MD: Mean Difference;RR: Relative risk; OR: Odds ratio; CI: Confidence interval

1. We chose the baseline risk from hospitalised COVID-19 patients who did not receive convalescent plasma and steroids from the paper by Guan, W. J, 2020, doi:10.1056/NEJMoa2002032.[3] This paper reports 96/173 severe patients did not receive steroids or hyperimmune plasma of which 10 patients died (information obtained from email communication). Hence, the baseline mortality risk is 10/96=10.4%. The median duration of hospitalization was 12.0 days (mean, 12.8).
2. We rated down two levels for indirectness since clinical and epidemiological characteristics of patients with influenza vary from COVID-2. We rated down one level for imprecision because the confidence interval included both important benefit and important harm
3. Evidence from observational studies beigins as low quality evidence We rated one level of indirectness since evidence came from SARS-CoV than COVID-19. Rated one level down for imprecision because the confidence intervals included both important benefit and important harm.
4. Recovery defined by an ordinal outcome (6 mutually exclusive categories) at 28 days: Death, in ICU, in-hospital with O2 support, in-hospital without O2 support, discharged but not normal, discharged and fully recovered. OR of >1 indicates treatment is better than control, interpreted as odds of better recovery is 1.24 times higher among those treated with hyperimmune plasma than control arm. This OR is similar across categories. We also assume the risk differences between treatment groups is same across categories of the outcome.
5. We chose the median duration of hospitalization from hospitalised COVID-19 patients with severe disease from the paper by Guan, W. J, 2020, doi:10.1056/NEJMoa2002032.[3]
6. This is the median days in ICU obtained from the control arm of RCTs including patients with severe influenza.
7. The baseline risk of serious adverse events obtained from control arm of studies including influenza (3 studies)
8. We rated down one level for indirectness for this safety outcome, inferring that the adverse effects are likely to be similar across viral illneses and one level down for imprecison because the confidence intervals included both important benefit and important harm

