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Authors' response

While appreciating the study we conducted¹, Pareek *et al*² reiterated the potential role of HCQ as a chemoprophylactic agent against SARS-CoV-2 infection. In the process, they highlighted the importance of protecting frontline HCWs. Data from UK and USA now reveal that compared to the general community, HCWs are at considerably increased risk of contracting SARS-CoV-2 infection³. Since early days of the pandemic, many of the HCWs have even lost their lives to SARS-CoV-2⁴.

In the latter part of the letter, the authors presented the case of Russia adopting recently the policy of HCQ chemoprophylaxis². They also offered supportive evidence generated from various cities of India, where HCWs presumably were able to keep SARS-CoV-2 at bay with the help of HCQ. However, it was not clear from the evidence showcased in the letter, if any comparison group was examined (non-receivers of HCQ among HCWs) to reach such conclusions. What really would help putting the debate around efficacy of HCQ - chemoprophylaxis against SARS-CoV-2 to rest, are the results of the ongoing randomized placebo controlled trials.

The suggestion to rapidly achieve an adequate state of maintenance with sufficient concentration of HCQ in the target tissues through more frequent dosing compared to the one currently advised in India would also benefit from an appropriately designed study. Concealment of allocation⁵ of the study participants to various regimens and keeping the investigators, participants as well as outcome assessors unaware of the assigned regimens would be the two crucial and challenging components while conducting such an investigation.

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