Table 1: Research Priorities for Coronavirus Disease 2019 (COVID-19) and the Renin-Angiotensin System (RAS)

Unanswered Questions	Suitable Study	Key Epidemiologic Considerations
Are cardiovascular disease, hypertension, or diabetes independently associated with COVID-19 mortality? What subtypes of cardiovascular disease does this apply to?	Observational	Retrospective hospital cohort feasible with electronic record, greater selection bias towards null
Are these associations mediated through acute respiratory distress syndrome, cardiomyopathy, or both? Is RAS blockade associated with COVID-19 outcomes?		Prospective community cohort less biased, but longer time to results Clustering may exist by country, region, or hospital
Is the association positive or negative? Are these class effects? Is there any effect of neprilysin inhibition or mineralocorticoid receptor antagonism? What duration of exposure or discontinuation matters? Does this association differ for mortality, acute respiratory distress syndrome, or cardiomyopathy?		Case definition based on + test: maximizes specificity, reduces sensitivity, will also bias to null Covariate effects may be nonlinear (e.g., age, interaction between hypertension and RAS blockade) Clear comorbidity definitions necessary to minimize misclassification bias
Can addition or removal of RAS blockade modify COVID-19 outcomes? Is this effect acute (within days) or chronic (over weeks to months)? Is it effective to start/stop medications once COVID-19 is already present or must it be prophylactic? What is the relative effect of addition or withdrawal of RAS blockade in different conditions compared to COVID-19?	Randomized Controlled Trial	Direction of trials (starting or withholding RAS blockade) should be informed by existing observational data Optimal outcomes: Primary (all-cause mortality) Secondary (respiratory failure, fulminant myocarditis, need for intensive care)