



Welcome to the Division of Continuing Medical Education's Post COVID-19 Condition 2026 Webinar Series



Treaty Acknowledgment

As we gather here today, we acknowledge we are on Treaty 2, 4, 5, 6, 8 and 10 Territories and the Homeland of the Métis. We respect that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes. We pay our respect to the First Nations and Métis ancestors of this place and reaffirm our relationship with one another.



Quick Poll

- Please select your role from the list, so we can see who is in the audience.
- Please rate your **knowledge level** about the Post COVID-19 Condition (PCC) topics **before** attending the webinar.

Zoom

Poll

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Submit



Accreditation Credits

- **Royal College of Physicians and Surgeons of Canada (RCPSC):**

This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification (MOC) program of the Royal College of Physicians and Surgeons of Canada and approved by the Division of Continuing Medical Education, College of Medicine, University of Saskatchewan. You may claim a maximum of 1.0 hours (credits are automatically calculated).

- **The College of Family Physicians of Canada (CFPC):**

This activity meets the certification criteria of the College of Family Physicians of Canada and has been certified by the Continuing Medical Education Division, University of Saskatchewan for up to 1.0 Mainpro+® Certified Activity credits.

- **Other Healthcare Professionals:**

Participation in this event may be included as part of the continuing education and competence programs established by individual professional associations.



Following this webinar...

Certificates:

Certificates will be emailed to those who attend the live session, within 10-14 business days post-webinar.



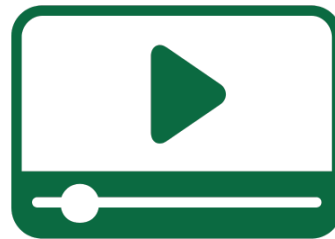
Evaluation:

A survey link will be shared in the chat at the end of this event. The link will also be included in the email distribution of the certificates.



Recordings:

This event will be recorded for future educational purposes and managed/distributed by CME.





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Questions:

- Throughout the presentation and during the Q&A period, attendees can submit written questions through **Zoom's Q&A function** (anonymously, if desired) or **chat function** (addressed to "everyone")
- During the presentation, attendees will be muted.
- During the Q&A period following the presentation, attendees can use the **raise hand function** and **unmute** to ask a question.

Video:

- Video has been enabled and is optional for attendees.
- During the Q&A period, any speakers, including our main presenters, will be recorded.





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- CME office recruits, communicates and manages all financial supporters, not the Scientific Planning Committee.
- 'Event Supporters' are kept separate from the educational content and listed as 'non-accredited' and 'optional' to attendees.
- 'Event Supporters' are not provided the opportunity to have commercial influence towards the educational content being delivered.
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- Brands/medical equipment/etc. are equally presented with no bias and/or with a generic brand listed.
- Survey results are documented, reviewed and addressed when bias is identified.



Dr. Gavin Y Oudit, MD, PhD, FRCPC, FCAHS

- Professor, Staff Cardiologist and Clinician-Scientist at the Mazankowski Alberta Heart Institute, University of Alberta.
 - His clinical and research activity places a primary emphasis on heart failure, cardiomyopathies, and COVID-19 impact on the cardiovascular system.
 - He is currently Director of the Heart Function and Cardiomyopathy Clinics.
 - Fellow of the Canadian Academy of Health Sciences and American Heart Association.
-





Presenter Disclosure

Presenter: **Gavin Y. Oudit**

Relationships with financial sponsors: Grants/Research Support, Speakers Bureau/ Honoraria, Consulting Fees, Patents, Other: **Sanofi-Genzyme, Takeda, CIHR, Long COVID Web, Apelin Analog, CAN-PCC Guidelines Committee member, Symposium Local Organizing Member.**



Long COVID, the Heart, and the Case for Taurine

Gavin Y. Oudit, MD, PhD, FRCPC, FCAHS

September 17, 2026



Learning Objectives

By the end of this presentation, learners will be able to:

- Describe the latest developments of research in Post COVID-19 Condition cardiac care.
- Identify emerging areas of research in Post COVID-19 Condition cardiac care.



Agenda

01 Long COVID in 2026

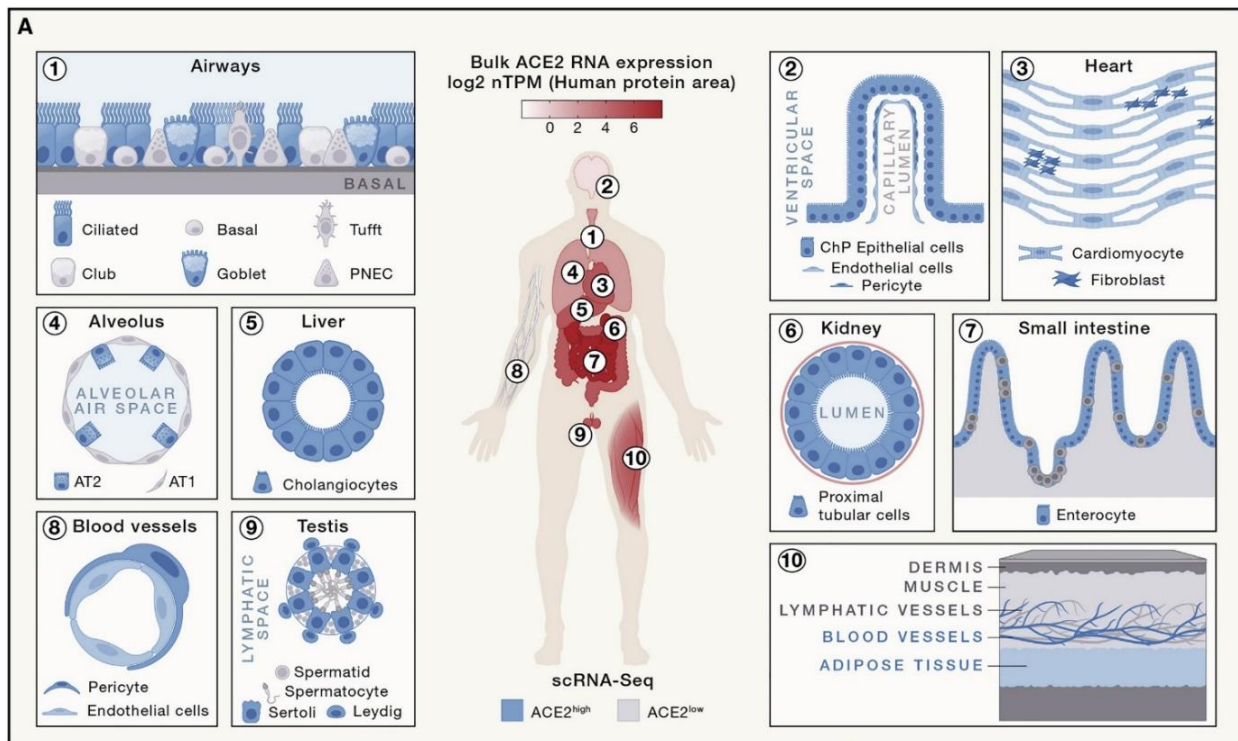
02 The Cardiovascular Sequelae

03 Taurine: Mechanism & Evidence

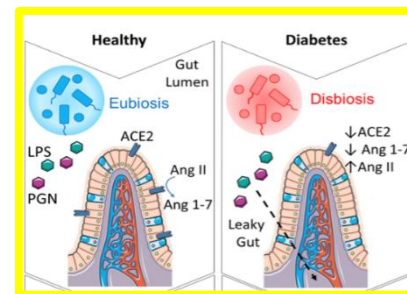
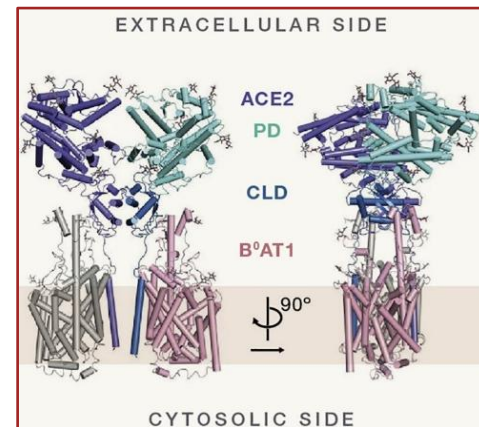
04 TaurineLC: Rationale, Design & Status



ACE2 Expression in the Human Body



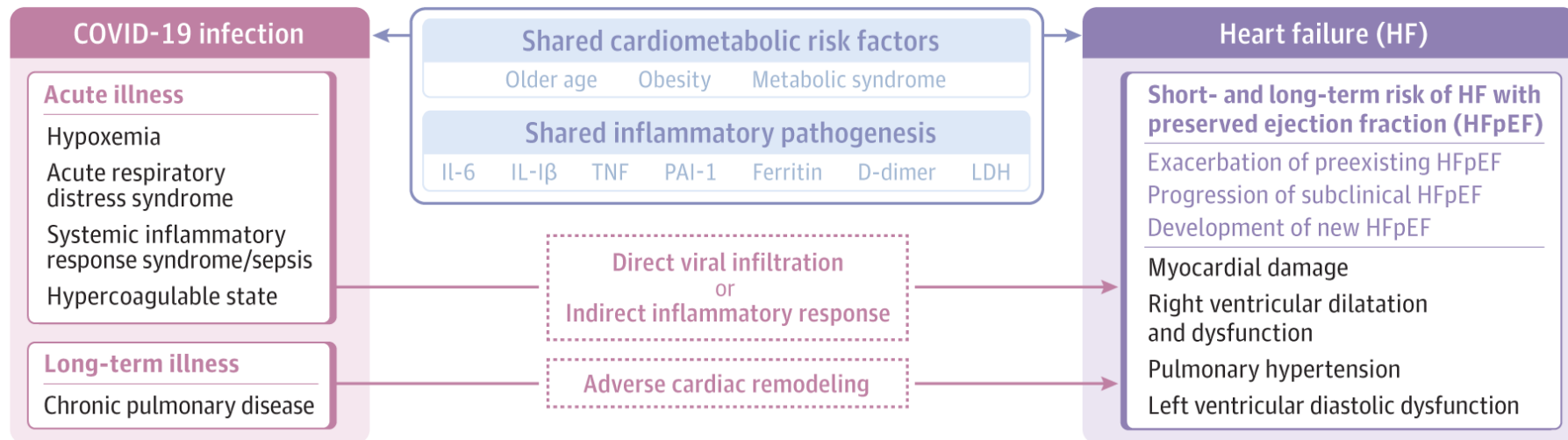
Intestinal ACE2 forms
Chaperone Complex
with BOAT1 Amino Acid Importer





Functional CV abnormalities in COVID-19

Figure. The Potential Intersection of Acute and Chronic Phases of COVID-19 and Risk of Heart Failure With Preserved Ejection Fraction



COVID-19 as an endothelial disease – systemic effects

COVID-19 indicates coronavirus disease 2019; LDH, lactate dehydrogenase; PAI-1, plasminogen activator inhibitor 1; TNF, tumor necrosis factor.

Source: Freaney et al. JAMA 2020.



The cellular and molecular cardiac tissue responses in human inflammatory cardiomyopathies after SARS-CoV-2 infection and COVID-19 vaccination

Received: 12 August 2024

Accepted: 10 January 2025

Published online: 24 February 2025

Check for updates

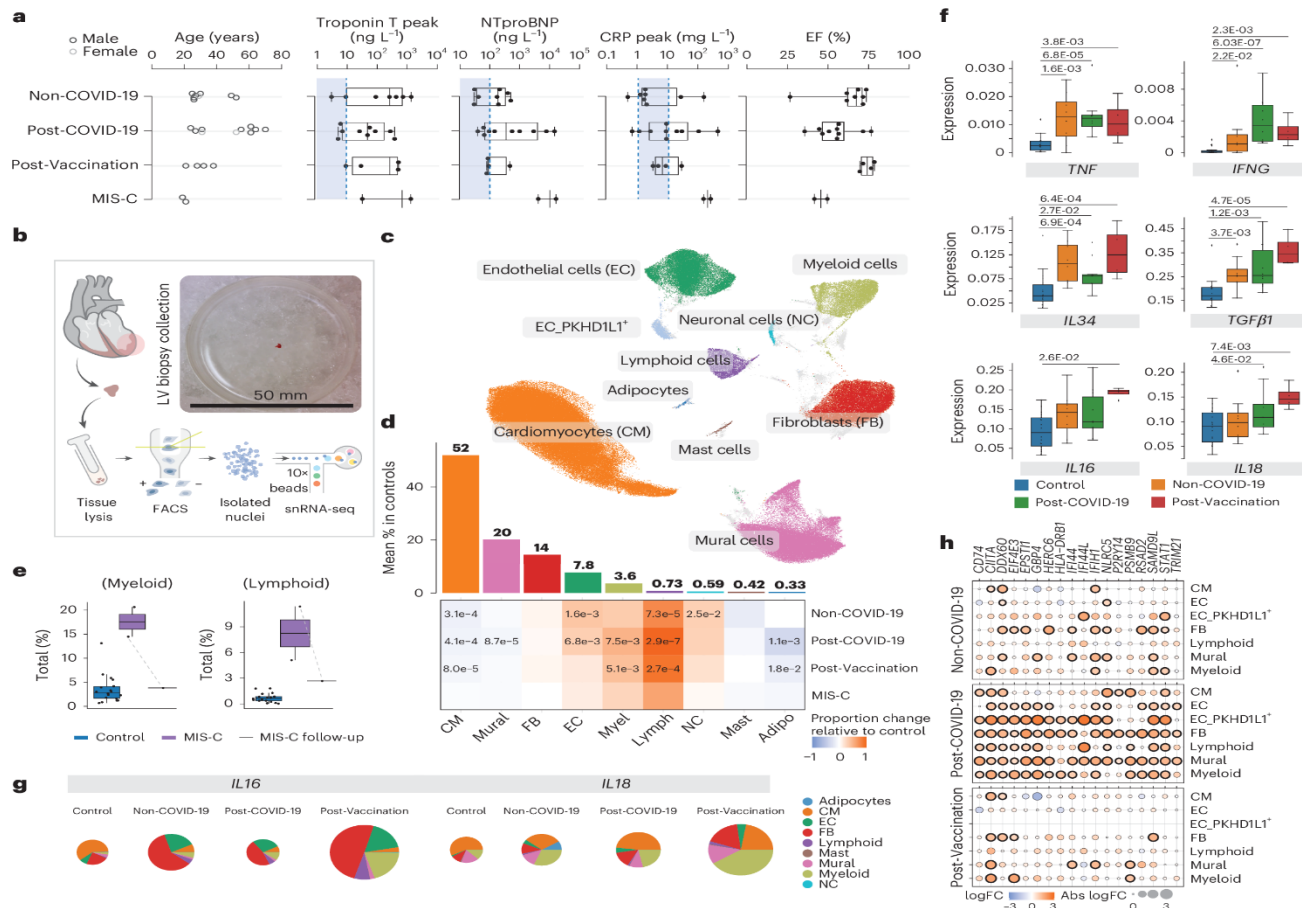
A list of authors and their affiliations appears at the end of the paper

Myocarditis, characterized by inflammatory cell infiltration, can have multiple etiologies, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection or, rarely, mRNA-based coronavirus disease 2019 (COVID-19) vaccination. The underlying cellular and molecular mechanisms remain poorly understood. In this study, we performed single-nucleus RNA sequencing on left ventricular endomyocardial biopsies from patients with myocarditis unrelated to COVID-19 (Non-COVID-19), after SARS-CoV-2 infection (Post-COVID-19) and after COVID-19 vaccination (Post-Vaccination). We identified distinct cytokine expression patterns, with interferon- γ playing a key role in Post-COVID-19, and upregulated *IL16* and *IL18* expression serving as a hallmark of Post-Vaccination myocarditis. Although myeloid responses were similar across all groups, the Post-Vaccination group showed a higher proportion of CD4⁺ T cells, and the Post-COVID-19 group exhibited an expansion of cytotoxic CD8⁺ T and natural killer cells. Endothelial cells showed gene expression changes indicative of vascular barrier dysfunction in the Post-COVID-19 group and ongoing angiogenesis across all groups. These findings highlight shared and distinct mechanisms driving myocarditis in patients with and without a history of SARS-CoV-2 infection or vaccination.

EMBs from patients after SARS-CoV-2 infection (including two SARS-CoV-2-related patients with MIS-C) or after SARS-CoV-2 vaccination as well as from patients with histologically confirmed lymphocytic myocarditis that were mostly taken before the pandemic or had no signs of SARS-CoV-2 infection.

Myeloid responses were similar across all groups, the Post-Vaccination group showed a higher proportion of CD4⁺ T cells, and the Post-COVID-19 group exhibited an expansion of cytotoxic CD8⁺ T and natural killer cells. Endothelial cells showed gene expression changes indicative of vascular barrier dysfunction in the Post-COVID-19 group (ACE2-pericyte-EC) and ongoing angiogenesis across all groups.

Distinct cellular and molecular signatures in Non-COVID-19, Post-COVID-19 and Post-Vaccination inflammatory cardiomyopathies



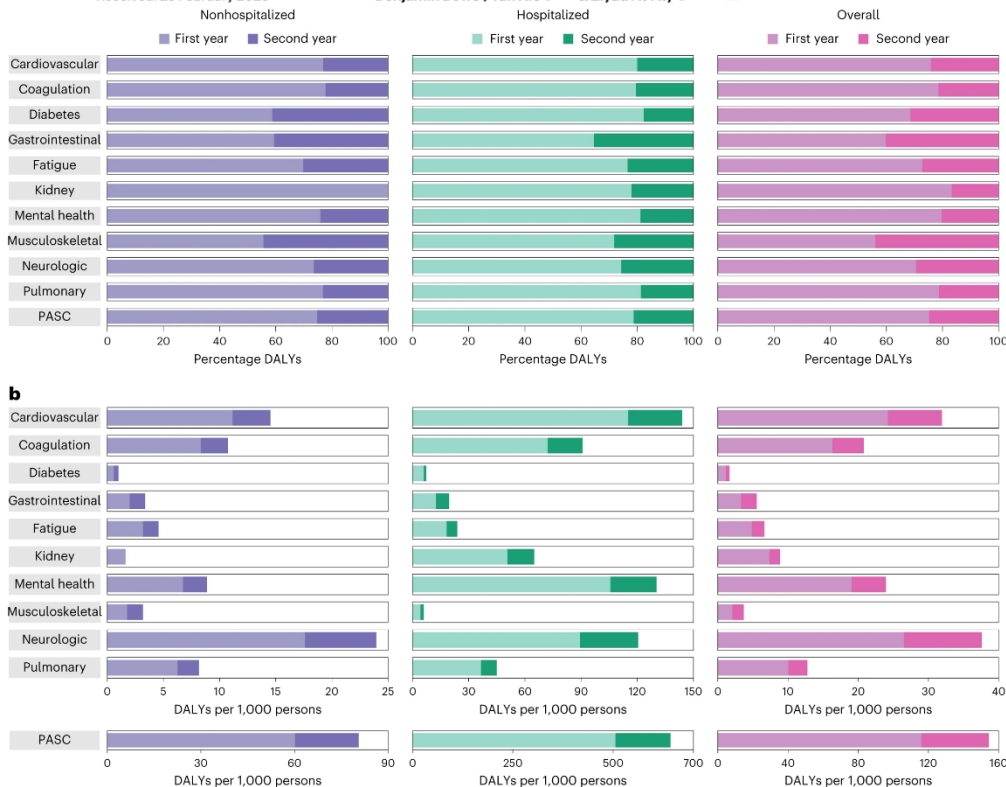
Article

<https://doi.org/10.1038/s41591-023-02521-2>

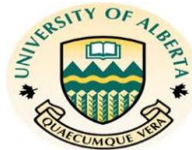
Postacute sequelae of COVID-19 at 2 years

Received: 23 February 2023

Benjamin Bowe¹, Yan Xie^{1,2,3} & Ziyad Al-Alay^{1,2,4,5,6}✉



We built a cohort of 138,818 individuals with SARS-CoV-2 infection and 5,985,227 noninfected control group from the US Department of Veterans Affairs and followed them for 2 years to estimate the risks of death and 80 prespecified post acute sequelae of COVID-19 (PASC) according to care setting during the acute phase of infection.



CLINICAL AND POPULATION STUDIES

COVID-19 Is a Coronary Artery Disease Risk Equivalent and Exhibits a Genetic Interaction With ABO Blood Type

James R. Hilser , Neal J. Spencer , Kimia Afshari, Frank D. Gilliland , Howard Hu , Arjun Deb , Aldons J. Lusis , W.H. Wilson Tang , Jaana A. Hartiala , Stanley L. Hazen *, and Hooman Allayee *

An analysis of UK Biobank health data that included adults who had mild to severe COVID-19 before vaccines were available found an increased risk of heart attack, stroke and death among those adults during the nearly 3-year follow-up period after COVID infection.

Data from the UK Biobank was used to identify COVID-19 cases (n=10 005) who were positive for polymerase chain reaction (PCR+)-based tests for SARS-CoV-2 infection (n=8062) or received hospital-based *International Classification of Diseases version-10 (ICD-10)* codes for COVID-19 (n=1943) between February 1, 2020 and December 31, 2020.

Population controls (n=217 730) and propensity score—matched controls (n=38 860) were also drawn from the UK Biobank during the same period.

- The elevated risk of heart attack, stroke and death linked to COVID-19 infection was found to be comparable to cardiovascular risk factors such as Type 2 diabetes, peripheral artery disease and cardiovascular disease.
- The study found that having a non-O blood type (A, B, AB) was associated with an increased risk of heart attack and stroke among those with COVID-19 infection before vaccines were available.
- People infected with COVID-19 might benefit from cardiovascular disease prevention treatments to lower risk of future cardiovascular outcomes.

Cardiovascular Disease and Long COVID



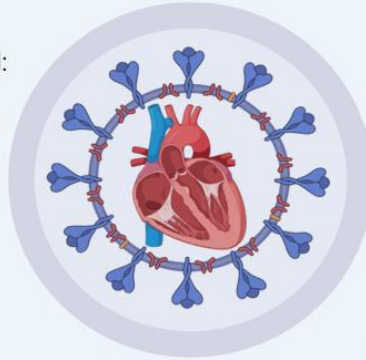
Pathophysiology

- Augmented immune response has a key role.
- Exact mechanisms remain unclear but the following may be implicated:
 - Genetic predisposition
 - Immune response mediated by B and T cells
 - Inflammatory response and auto-antibodies



Risk Factors

- Patients with pre-existing heart failure or ischaemic heart disease have increased risk of developing Long COVID syndrome.
- Obesity and diabetes are also important risk factors.
- Evidence is conflicting about other cardiac conditions (hypertension, atrial fibrillation etc).



Complications

- New onset cardiovascular diseases have been noted in patients with Long COVID syndrome (commonly hypertension and diabetes).
- Long COVID may also have an impact on the myocardium (resulting in myocardial oedema, inflammation or fibrosis and potentially functional impairment).



Prevention & Treatment

- Optimal control of modifiable risk factors may be of value in disease prevention but there is lack of definitive evidence.
- Vaccination and medications (antivirals, metformin) may have a role in the prevention of Long COVID.
- No specific treatment found to be effective and efficient but the use of antivirals and cardio-selective treatments may ameliorate symptoms

Created with BioRender.com



CANADIAN GUIDELINES FOR
POST COVID-19 CONDITION

COVERAGE OF SIX PCC GUIDELINE TOPICS

PREVENTION OF PCC

For example:

- Primordial prevention (of COVID-19)
- Primary prevention of PCC (incl. pharmacological interventions)
- Risk stratification, prognostic factors

TESTING, IDENTIFICATION & DIAGNOSIS RELATED TO PCC

For example:

- Medical examination
- Diagnostic and other tests

PHARMACOLOGICAL & NON-PHARMACOLOGICAL CLINICAL INTERVENTIONS FOR PCC

For example:

- Rehabilitation
- Antiviral therapy
- Anticoagulation, antiplatelets
- Traditional healing approaches, complementary, alternative, holistic treatments
- Interventions at population and individual levels

NEUROLOGICAL & PSYCHIATRIC TOPICS

For example:

- Screening
- Post exertional malaise
- Fatigue
- Brain fog
- Cognitive impairment

PEDIATRIC & ADOLESCENT TOPICS

For example:

- Special considerations
- Caregivers
- Schools

HEALTH CARE SERVICES & SYSTEMS, SOCIAL SUPPORT

For example:

- Primary care, virtual care, specialist referral
- PCC clinics
- Transitions in care
- Co-construction of treatment plans
- Social support
- Work accommodations and special considerations

MANAGEMENT

Holistic Healthcare Approaches, Multi-Modal Care

MONITORING, DISCHARGE, & FOLLOW-UP

PREVENTION OF OTHER HEALTH CONDITIONS RELATED TO PCC

RECOMMENDATIONS FOR CANADIAN RESIDENTS, WITH SPECIAL ATTENTION TO EQUITY-DESERVING POPULATIONS

Addressing distinct and diverse needs, with culturally sensitive approaches

<https://can-pcc.recmap.org/>

Long COVID Remains a Major, Unresolved Burden

6–30%

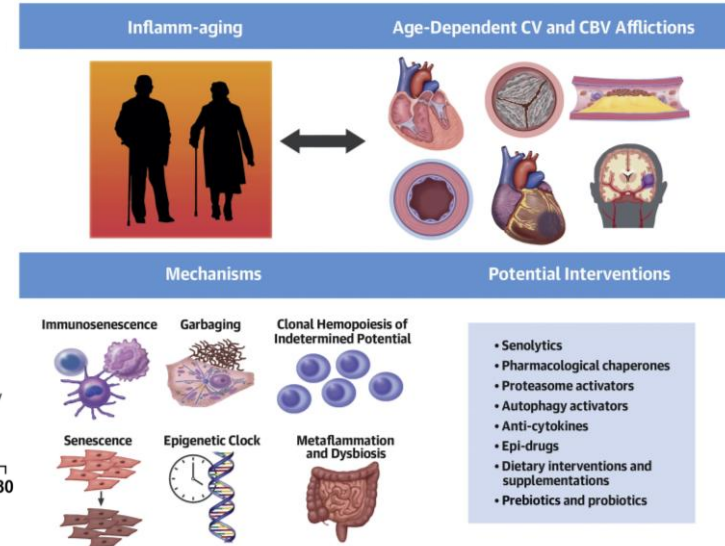
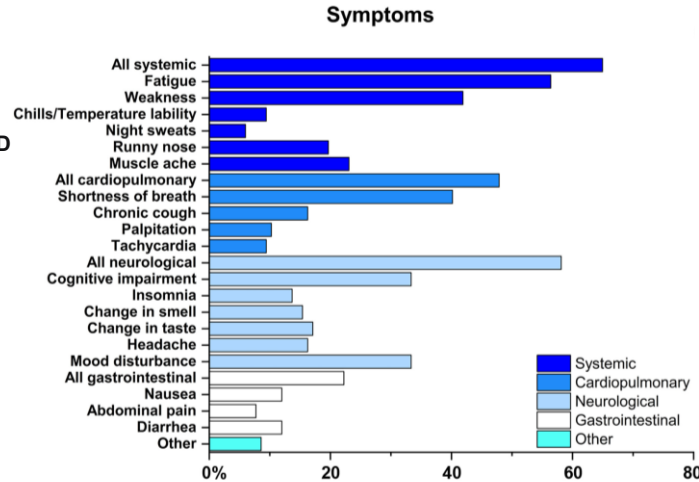
of COVID-19 survivors develop Long COVID

65M+

people affected worldwide

0

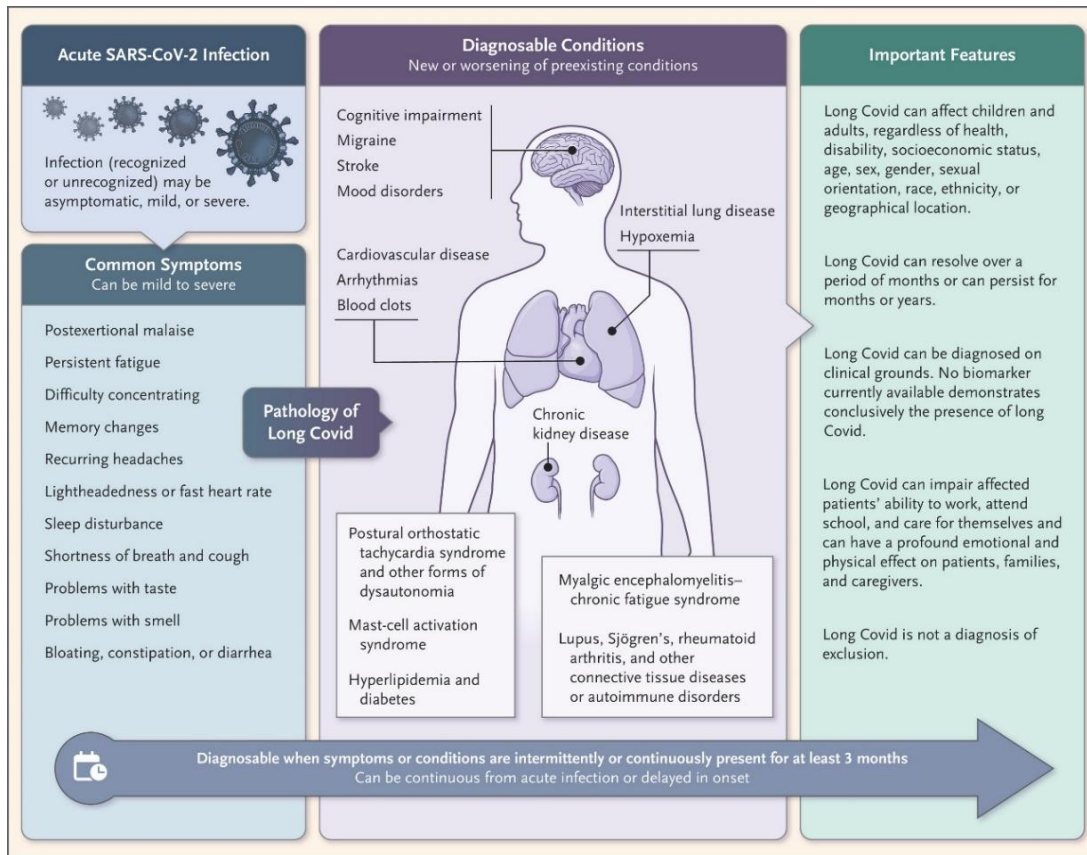
disease-modifying therapies approved



- Persistent, multisystem disease: neurological, pulmonary, cardiovascular, metabolic and gastrointestinal disorders persist years beyond the initial infection.
- Most prevalent long COVID symptoms includes fatigue, general weakness, dyspnea, and cognitive impairment.
- Mechanistically linked to accelerated biological aging: chronic inflammation, gut dysbiosis, cellular senescence, mitochondrial dysfunction, oxidative stress and telomere attrition.
- These processes mirror “inflammaging,” a recognised driver of cardiovascular, metabolic, and neurocognitive disease.



Diversity, duration, diagnosis, and disability of this infection-associated chronic condition



Disease state of a patient with long COVID, starting with symptoms of acute infection by SARS-CoV-2

- Symptoms of SARS-CoV-2 that occur at least 3 months from the time of the acute infection.
- Last at least 2 months.
- Single or multiple organ systems may be involved.
- >200 symptoms have been connected to PCC.
- Cannot be explained by an alternative diagnosis.

The Cardiovascular System: A Core Target Organ

Structural & ischemic disease

Myocarditis, ischemic and non-ischemic heart disease, and heart failure are recognised as core cardiovascular sequelae of Long COVID.

Arrhythmia

Meta-analysis of 14 cohorts links Long COVID to higher risk of atrial fibrillation, sinus tachycardia, bradycardia and ventricular arrhythmias.

Stroke & thrombosis

Pooled risk of stroke is 1.71× higher than non-COVID controls. Thrombotic events risk are also elevated.

Persists after mild disease

Elevated long-term cardiovascular risk is seen even in non-hospitalized patients, not just those with severe acute illness.

Shared mechanism: persistent activation of innate and adaptive immune pathways drives endothelial injury, thrombo-inflammation and adverse myocardial remodeling, which are the same inflammaging pathway implicated in Long COVID broadly.

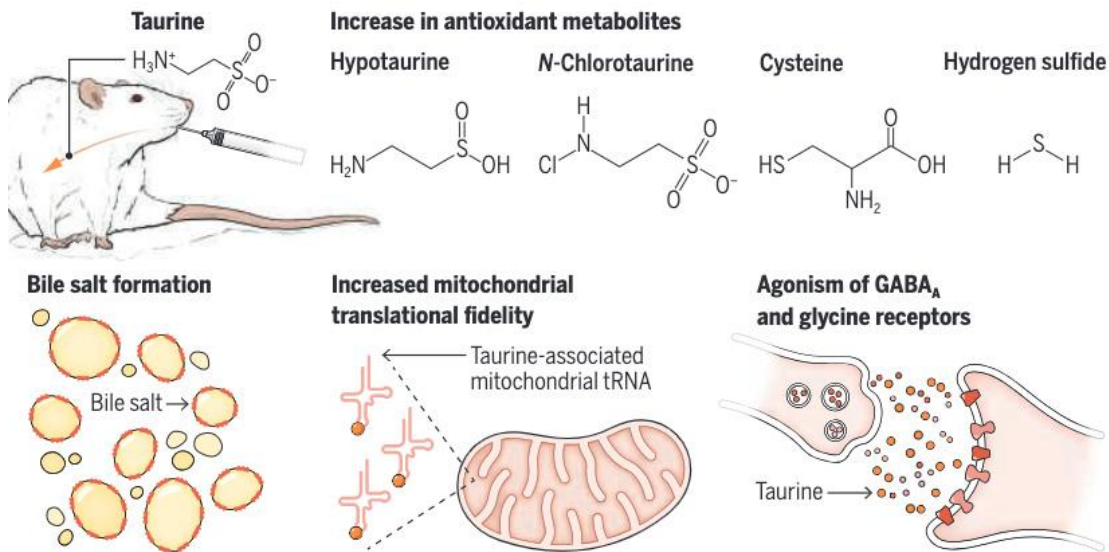
- Xie, Xu, Bowe & Al-Aly. Long-term cardiovascular outcomes of COVID-19. *Nat Med* 2022;28:583–590
- Zhang et al. Cardiovascular outcomes in long COVID-19: systematic review & meta-analysis. *Front Cardiovasc Med* 2025;12:1450470
- Boskabadi et al. Increased arrhythmia risk in Long COVID: systematic review & meta-analysis. *J Arrhythmia* 2026
- Liu et al. Cardiovascular sequelae of Long COVID: immune dysregulation as central drivers. *Front Immunol* 2026;17:1815269



Taurine: A Mechanistically Plausible Candidate

How might taurine increase health and longevity?

Supplemental taurine extends mouse life span, but the mechanism is unclear. Possible explanations include accumulation of multiple antioxidant and signaling metabolites, that taurine is a key component of bile acids and might therefore alter nutrient absorption, and that incorporation of taurine into mitochondrial transfer RNAs (tRNAs) can increase mitochondrial translational fidelity. Taurine is also an agonist of γ -aminobutyric acid type A ($GABA_A$) and/or glycine receptors and so might have effects on neurotransmission.



McGaunn & Baur. Taurine linked with healthy aging. *Science* 2023;380:1010–1011



Taurine's Cardiovascular Pharmacology

Proposed vascular mechanism

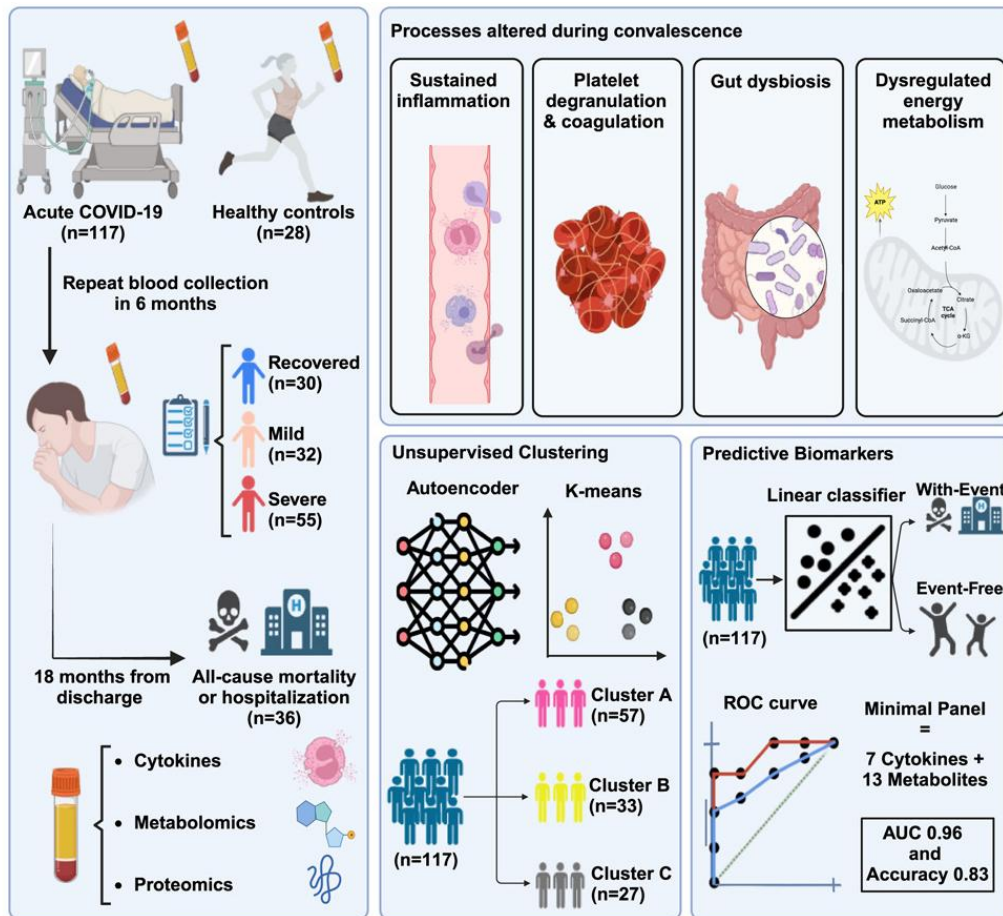
- Increases plasma hydrogen sulfide (H_2S) and upregulates its synthesis
- Inhibits calcium influx into vascular smooth muscle cells
- Stimulates endothelial nitric oxide synthase (eNOS)
- Net effect: promotes both endothelial and non-endothelial vasodilation, directly countering the endothelial dysfunction seen in Long COVID.

Clinical & preclinical evidence

- Cardioprotective in preclinical model of iron-overload cardiomyopathy through reduced oxidative stress, improved cardiac function (Oudit et al. Circulation 2004)
- Meta-analysis: taurine lowers resting blood pressure (Waldron et al. Curr Hypertens Rep 2018)
- Meta-analysis: measurable cardiovascular benefit across trials (Tzang et al. Nutr J 2024)
- Meta-analysis: taurine improves symptoms and clinical status in heart failure and dilated cardiomyopathy (McGurk et al. Wellcome Open Res 2022)

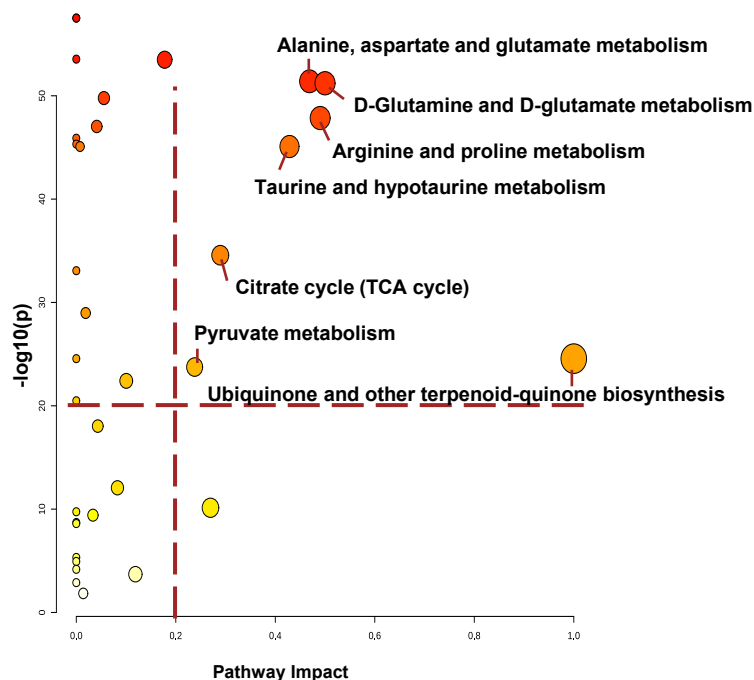


Multi-omics Study Summary

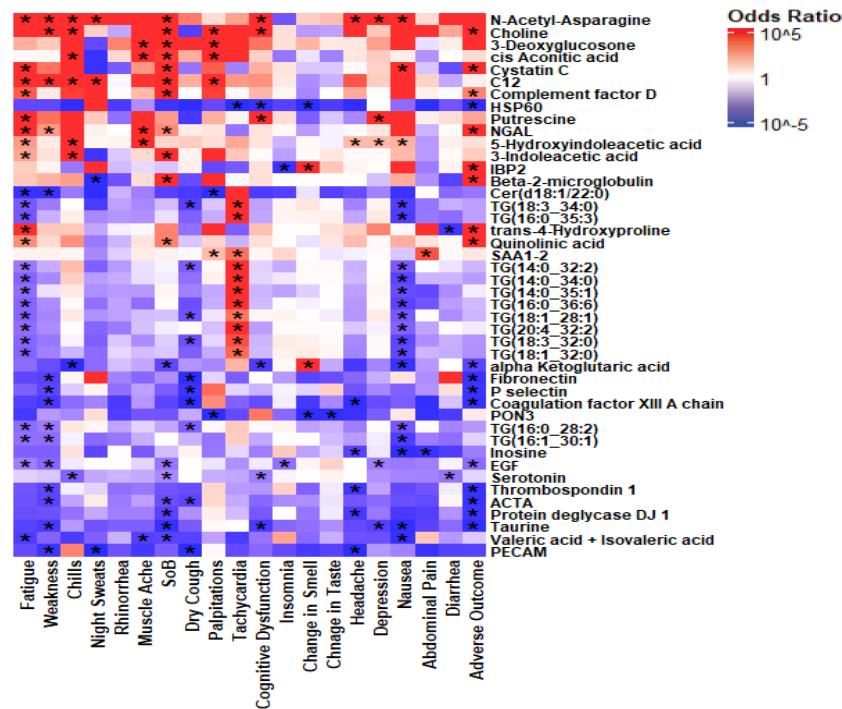


Dysregulated Taurine Metabolism in Long COVID and Tracks with Symptoms

Dysregulated Metabolic Pathways in Long COVID vs CTR

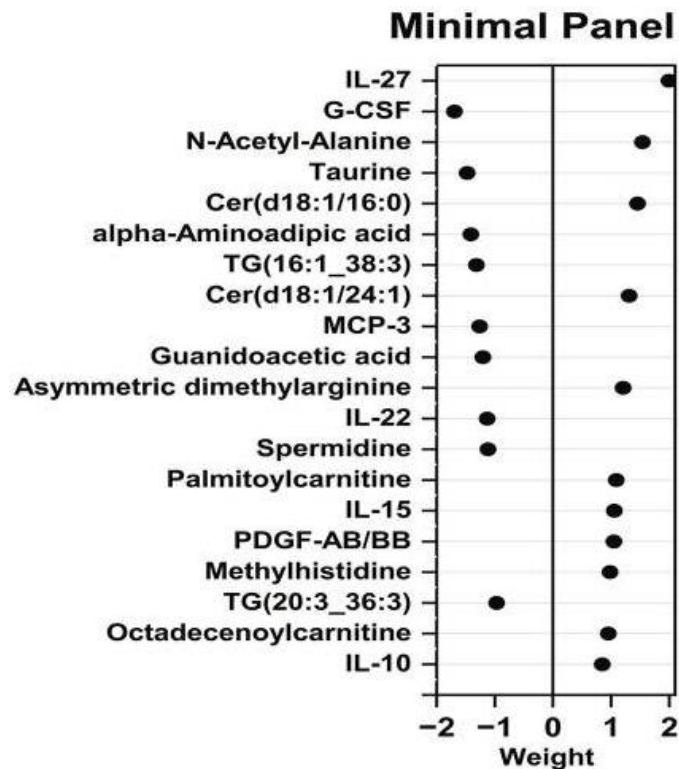
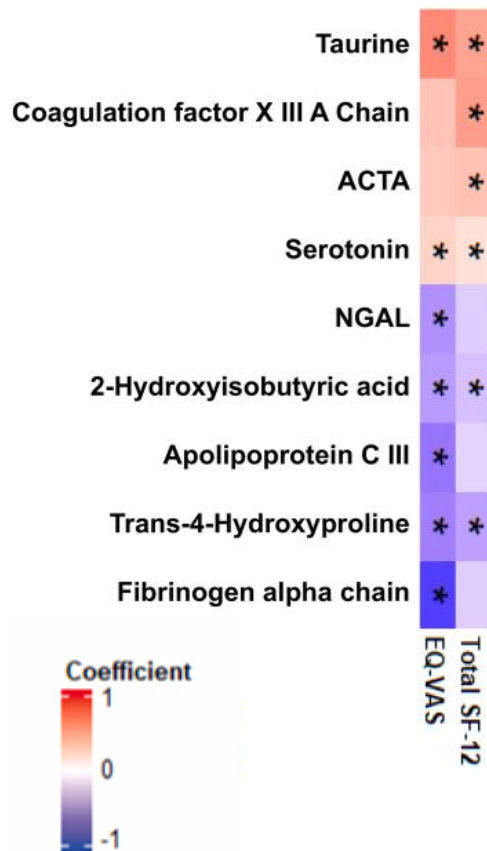


Association with Symptoms



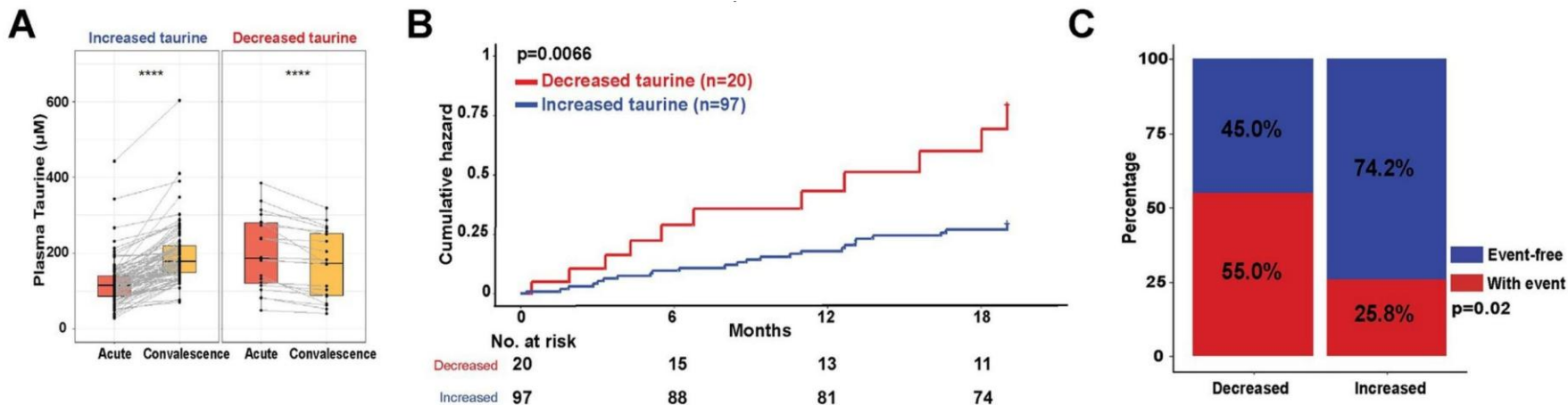


Association with Quality of Life and Clinical Outcomes





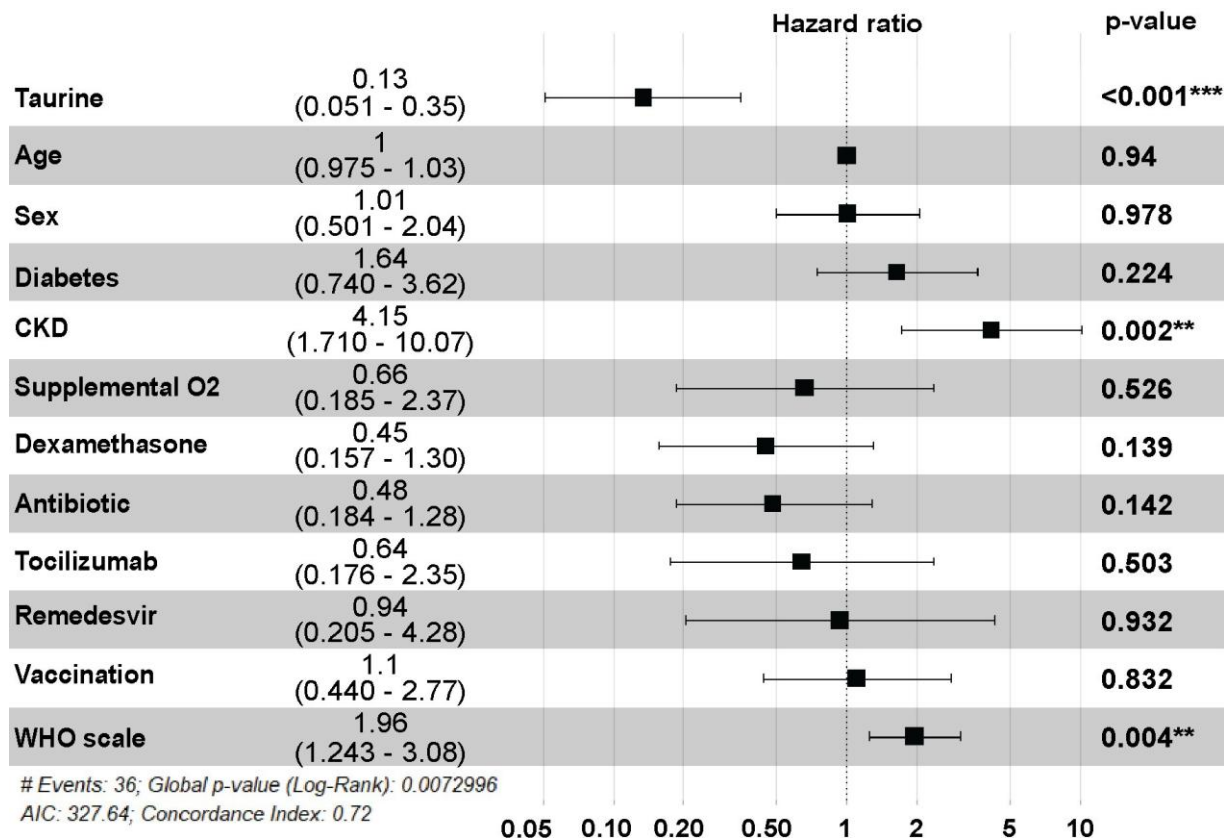
Rising Taurine Levels After Acute Infection Predicts Better Outcomes



n=117 followed from acute infection to 6.3-month convalescence, with adverse-outcome follow-up to a median of 17.4 months



Taurine Trajectory Independently Predicts Outcome





Systematic Review Across 27 RCTs (n=1,030)

- Significant improvement across glycemic, lipid, inflammatory and oxidative-stress markers with taurine supplementation
- Dose-response relationship (TNF- α , IL-6) supports 3,000 mg/day as the efficacious daily dose
- Well tolerated: only mild GI discomfort at the highest dose tested (6,000 mg/day)

Efficacy of taurine supplementation on systemic processes implicated in PASC

Population



27 Clinical trials, 1030 Patients, 50.5% Females

Intervention

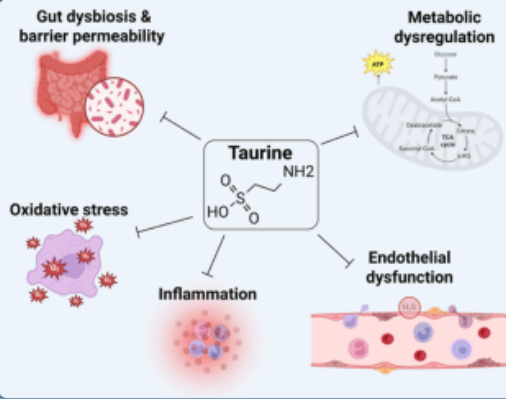


Taurine (median: 3000 mg/d, 8 weeks)

Comparison



Placebo or standard of care



Outcome

SMD [95% CI]

Glycemic Indices

HbA1c

Fasting blood glucose

Fasting insulin

HOMA-IR

Lipid Profile

Total cholesterol

Triglycerides

HDL

LDL

Inflammation

CRP

TNF- α

IL-6

IL-10

Oxidative Stress

MDA

Cardiovascular

Systolic BP

Diastolic BP

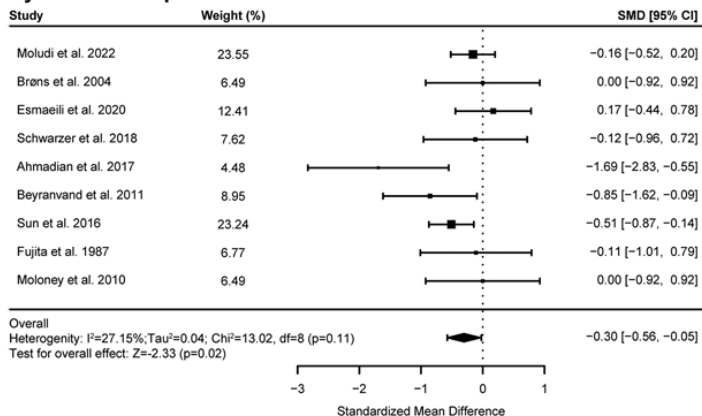
Heart rate

Exercise Capacity

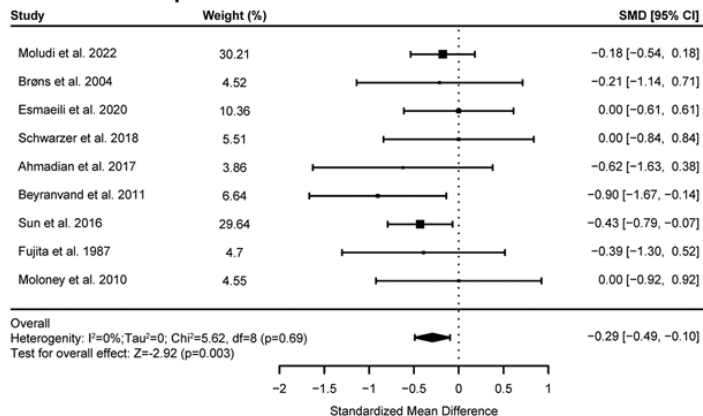
Neurocognition

Taurine Improves Blood Pressure and Exercise Capacity Across Trials

Systolic blood pressure



Diastolic blood pressure



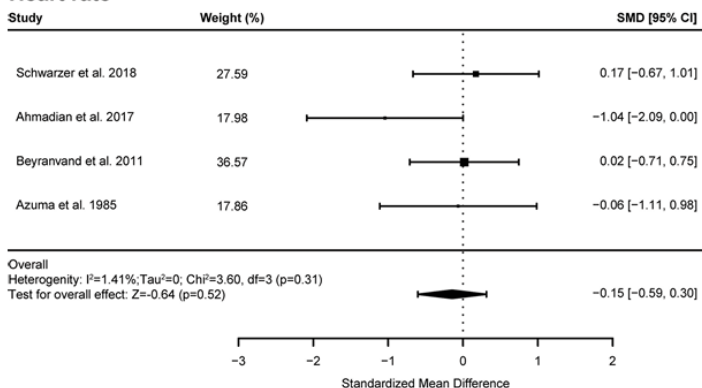
-0.30

Systolic BP
(SMD, 95% CI -0.56 to -0.05)

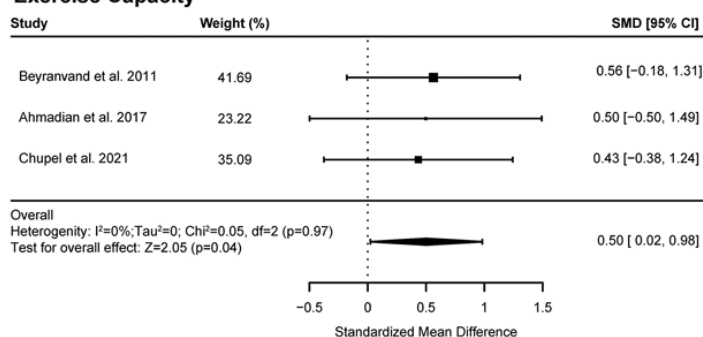
-0.29

Diastolic BP
(SMD, 95% CI -0.49 to -0.10)

Heart rate



Exercise Capacity



+0.50

Exercise capacity
(SMD, 95% CI 0.02 to 0.98)



The Case for TaurineLC

1

Prognostic signal

Rising plasma taurine after acute infection independently predicts better clinical outcomes in all-cause mortality and re-hospitalization.

2

Mechanistic plausibility

Anti-inflammatory, antioxidant, endothelial and mitochondrial actions map directly onto Long COVID's inflammaging pathology.

3

Trial-level evidence

27 RCTs (n=1,030) show benefit on inflammatory, metabolic and cardiovascular outcomes, at a well-tolerated dose.

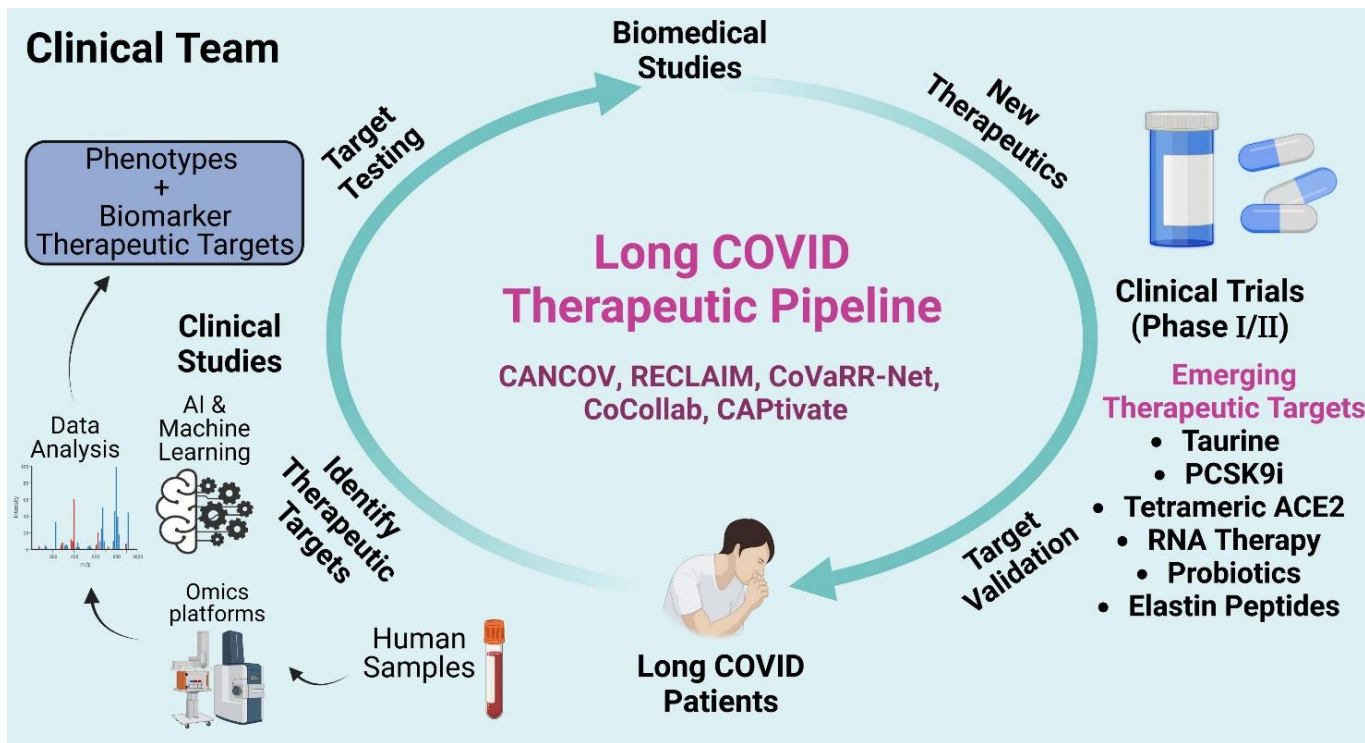
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No effective treatment exists

Long COVID remains without an approved disease-modifying therapy while taurine already has a favourable safety record.



From Bench to Trial: The Long COVID Therapeutic Pipeline





TaurineLC: Trial Design at a Glance

Design

- Phase II/III, prospective, double-blind, placebo-controlled RCT.
- Adults ≥ 18 years with Long COVID (RECLAIM Network companion trial)
- 2 arms, randomised 2:1 (taurine : placebo)
- Taurine 2 $\times$ 675 mg capsules twice daily (2,700 mg/day) or matched placebo.
- 12 weeks treatment + 12 weeks follow-up = 24 weeks total.
- Blinded: participant, investigator, care provider, study coordinator, pharmacist.

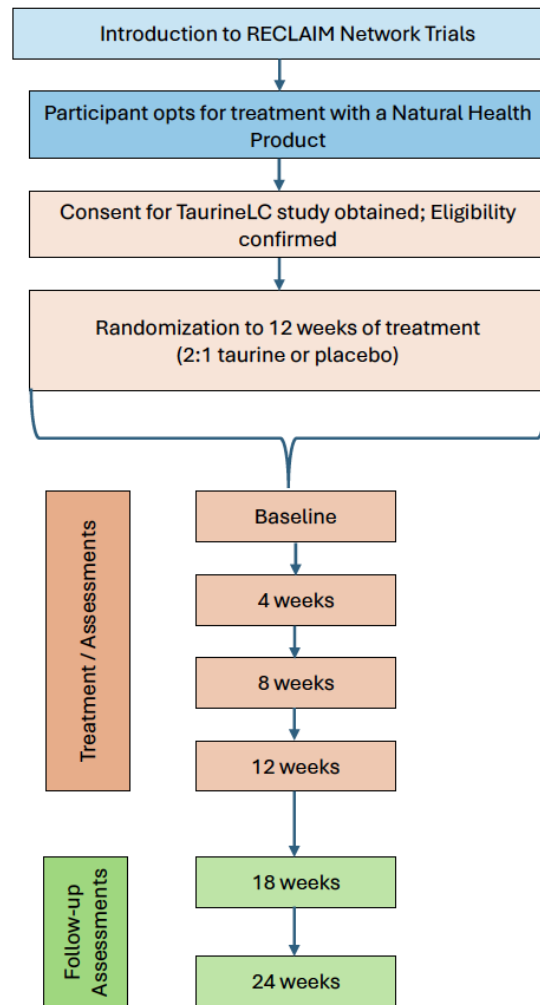
Endpoints & cardiovascular monitoring

- Co-primary: Modified Fatigue Impact Scale (fatigue) and Trail-Making Test B/A ratio (cognition), baseline to 3 months.
- Secondary: symptom burden, post-exertional malaise, functional status, quality of life.
- Built-in cardiovascular assessment: orthostatic vitals, 6-minute walk test with continuous oximetry, vital signs at baseline, 12 and 24 weeks.
- Bayesian adaptive design — no fixed sample size; interim analyses every 120 participants.



Study Flowchart

- Participants opt in to the taurine trial within the RECLAIM Network and are consented for TaurineLC specifically.
- Randomised 2:1 (taurine : placebo) after eligibility is confirmed.
- 12 weeks of treatment with assessments at baseline, 4, 8 and 12 weeks.
- 12 further weeks of follow-up with assessments at 18 and 24 weeks.





Eligibility

Inclusion Criteria

- ❖ ≥ 18 years old
- ❖ Positive COVID test or presumed COVID infection at least 3 months prior to randomization.
- ❖ Stable treatment regimen for treatable symptoms.
- ❖ Lingering COVID-19 symptoms beyond 3 months from onset of acute COVID and have lasted at least 2 months.
- ❖ Lingering symptoms present at randomization.
- ❖ Must agree to use highly effective method of contraception.
- ❖ Must be able to provide consent and willing and able to comply with study requirements.
- ❖ Discontinue any medications prescribed for treating fatigue or cognition at least 4 weeks before randomization.

Exclusion Criteria

- ❖ Patients who had mechanical ventilation or ECMO for COVID-19.
 - ❖ Current end-organ failure, organ transplant or current hospitalization.
 - ❖ Contraindications to the study intervention.
 - ❖ Currently on the study intervention.
 - ❖ Could be eligible if stop taking taurine for 4 weeks prior to randomization.
 - ❖ Co-enrolment on another interventional trial.
 - ❖ Currently pregnant or breastfeeding.
 - ❖ Currently enrolled on another trial for neurocognitive symptoms in LC.
-



Study Assessments

Key Assessments for Primary Outcomes

Fatigue – Modified Fatigue Impact Scale (MFIS), administered at Baseline, 12 weeks and 24 weeks.

Cognition – Connecting the Dots (Trail-Making Tests A & B) in the online TestMyBrain cognitive tests, administered at Baseline, 12 weeks and 24 weeks.

Note: These assessments should be prioritized for completion

Other Assessments

Symptom Checklist

TestMyBrain cognitive tests

Post-COVID Functional Scale (PCFS)

Reintegration to Normal Living Index (RNLI)

Post-Exertional Malaise (PEM)

Health-Related Quality of Life (SF-36 v.1)

Montreal Cognitive Assessment (MoCA) – blind version

BORG Dyspnea Scale

Orthostatic Vitals/Stand Test

6-Minute Walk Test with Continuous Oximetry

Clinical Frailty Scale

Global Symptom Bother Scale (1 question, weekly)

Patient Health Questionnaire (PHQ-9)

Generalize Anxiety Scale (GAD-7)

Health Care Utilization Assessment

Primary Daily Activity & Work Status Assessment



Study Intervention



Taurine

- ▶ Naturally occurring amino sulfonic acid found in the body (brain, retina, heart, blood cells)
- ▶ Sourced from Advanced Orthomolecular Research (AOR) in Calgary, AB.
- ▶ Each capsule contains 675 mg of taurine.

Placebo

- ▶ Identical to the taurine capsule in appearance, taste and packaging.
- ▶ Sourced from Advanced Orthomolecular Research (AOR) in Calgary, AB.



Treatment



- ▶ Participants will take 2 capsules twice daily, for 12 weeks.
 - ▶ Total daily taurine dose = 2700 mg
 - Considered safe for long term use
 - ▶ Doses should be taken a minimum of four hours apart.
 - ▶ Preferably as close to 12 hours apart as possible.
 - ▶ Can be taken with or without food.

- ▶ Participants will be asked to complete a dosing diary twice daily.
 - ▶ Record date and time doses taken.
 - ▶ Record any side effects.



Enrolling

since 18 Nov 2025

~300

target participants (240–360 range)

5

sites across Canada

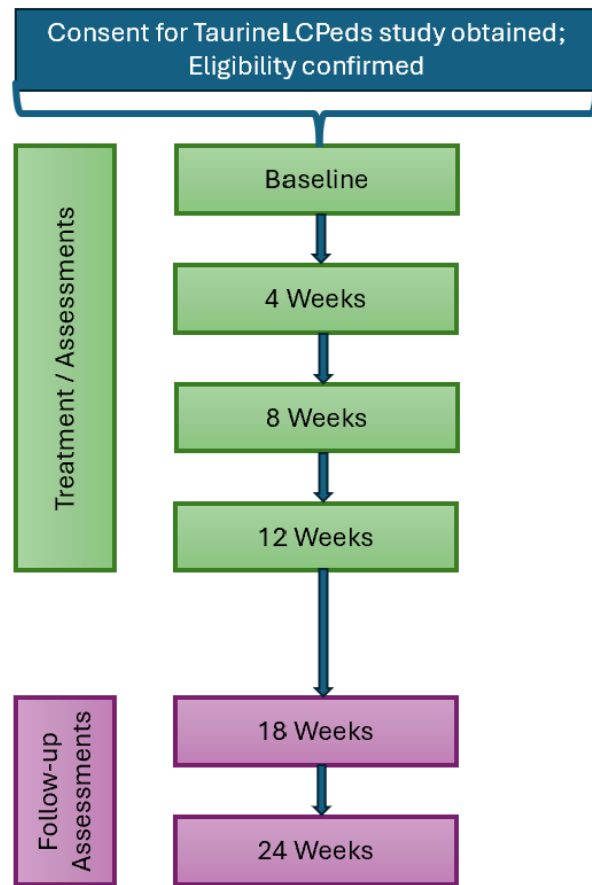
Phase II/III

NCT06721949

Trial Status

- Open-label pediatric/adolescent companion trial launched: TaurineLCPeds (NCT07682402), Phase I/II, protocol v1.0 dated 22 July 2026.
- The pediatrics arm is exploratory in nature with primary outcome being changes in plasma taurine levels following supplementation.
- Both trials share the same biological rationale: restoring plasma taurine to address the inflammaging pathology common to Long COVID at any age.

TaurineLCPeds Study Schema





Thank you for attending!



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