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COVID-19 Clinical Guidance for Adult Patients with Rheumatic Diseases

Version 2
Revised February 1, 2021

Developed by the ACR COVID-19 Clinical Guidance Task Force
This summary was initially approved by the ACR Board of Directors on April 11, 2020.

*A full paper (Version 1) was published on April 29, 2020, then copyedited/slightly revised into its final format, published in the August 2020 issue of Arthritis & Rheumatology.**

*New recommendations regarding reinitiating treatment following COVID-19 were added to this summary on July 13, 2020, and subsequently added to the full paper (Version 2), published in the September 2020 issue of Arthritis & Rheumatology.***

*Modifications specific to holding anti-malarial therapy after SARS-CoV-2 exposure or infection were made to this summary on November 16, 2020, and subsequently added to the full paper (Version 3), published in the February 2021 issue of Arthritis & Rheumatology.****

Purpose

The purpose of this document is to provide guidance to rheumatology providers on the management of adult rheumatic disease patients in the context of the COVID-19 pandemic. These statements are not intended to replace clinical judgment. Modifications made to treatment plans, particularly in complex rheumatic disease patients, are highly disease-, patient-, geography-, and time-specific and, therefore, must be individualized as part of a shared decision-making process. This guidance is provided as part of a 'living document,' recognizing rapidly evolving evidence and the anticipated need for frequent updates as such evidence becomes available.

Methods

The North American Task Force, including 10 rheumatologists and 4 infectious disease specialists, convened on March 26, 2020. Clinical questions were collated, and an evidence report was generated and disseminated to the panel. Questions and drafted statements were reviewed and assessed using a well-established method of consensus building (modified Delphi process). This included two rounds of asynchronous anonymous voting by email and two webinars including the entire panel. Panel members voted on agreement with draft statements using a numeric scoring system, and consensus was determined to be "low" (L), "moderate" (M) or "high" (H), based on the dispersion in voting results. To be approved as guidance, median votes were required to correlate to pre-defined levels of agreement (with median values interpreted as "agreement," "uncertainty" or "disagreement") with either moderate or high levels of consensus.

Recommendations

General statements for patients with rheumatic disease:

- The risk of poor outcomes from COVID-19 appears to be related primarily to general risk factors such as age and comorbidity (H).
- Patients should be counseled on general preventive measures, e.g., social distancing and hand hygiene (H).
- As part of a shared decision-making process between patients and rheumatology providers, select measures to reduce healthcare encounters and potential exposure to SARS-CoV-2 (beyond general preventive measures) may be reasonable, e.g., reduced frequency of lab monitoring, optimal use of telehealth, increased dosing intervals between intravenous medications) (M/H).

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- If indicated, glucocorticoids should be used at the lowest dose possible to control rheumatic disease, regardless of exposure or infection status (M/H).
- Glucocorticoids should not be abruptly stopped, regardless of exposure or infection status (H).
- If indicated, angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) should be continued in full doses or initiated (M/H).

Ongoing treatment of stable patients in the absence of infection or SARS-CoV-2 exposure:

- Hydroxychloroquine or chloroquine (HCQ/CQ), sulfasalazine (SSZ), methotrexate (MTX), leflunomide (LEF), immunosuppressants (e.g., tacrolimus, cyclosporine, mycophenolate mofetil, azathioprine), biologics, Janus kinase (JAK) inhibitors and non-steroidal anti-inflammatory drugs (NSAIDs) may be continued (this includes patients with giant cell arteritis with an indication, in whom IL-6 inhibitors should be continued, if available) (M/H).
- Denosumab may still be given, extending dosing intervals to no longer than every 8 months, if necessary to minimize healthcare encounters (M).
- For patients with a history of vital organ-threatening rheumatic disease, immunosuppressants should not be dose-reduced (M).

In patients with SLE:

- In newly diagnosed disease, HCQ/CQ should be started at full dose, when available (H).
- In pregnant women with SLE, HCQ/CQ should be continued at the same dose, when available (H).
- If indicated, belimumab may be initiated (M).

Treatment of newly diagnosed or active rheumatic diseases, in the absence of infection or SARS-CoV-2 exposure:

Active Inflammatory Arthritis:

- For patients well-controlled on HCQ/CQ, this disease-modifying anti-rheumatic drug (DMARD) should be continued, when available; when unable to access (including in patients with active or newly diagnosed disease), switching to a different conventional synthetic DMARD (either as monotherapy or as part of combination therapy) should be considered (M/H).
- For patients well-controlled on an IL-6 inhibitor, this DMARD should be continued, when available; when unable to access the agent, switching to a different biologic should be considered (M). The panel noted uncertainty regarding the use of JAK inhibitors in this situation.
- For patients with moderate to high disease activity despite optimal conventional synthetic DMARDs, biologics may be started (H). The panel noted uncertainty regarding the use of JAK inhibitors in this situation.
- For active or newly diagnosed inflammatory arthritis, conventional synthetic DMARDs may be started or switched (M).
- If indicated, low-dose glucocorticoids (≤10 mg prednisone equivalent) or NSAIDs may be started (M/H).

Other Rheumatic Diseases:

- In patients with systemic inflammatory or vital organ-threatening disease (e.g., lupus nephritis or vasculitis), high-dose glucocorticoids or immunosuppressants may be initiated (M).
- In the context of a drug shortage due to COVID-19, new HCQ/CQ prescriptions for non-FDA approved indications should be avoided (H).

Ongoing treatment of stable patients following SARS-CoV-2 exposure (without symptoms related to COVID-19):

- SSZ and NSAIDs may be continued (M/H).

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- HCQ/CQ, immunosuppressants, non-IL-6 biologics, and JAK inhibitors should be stopped temporarily, pending 2 weeks of symptom-free observation (M). The panel noted uncertainty re: temporarily stopping MTX or LEF in this situation.
- In select circumstances, as part of a shared decision-making process, IL-6 inhibitors may be continued (M).

Rheumatic disease treatment in the context of documented or presumptive COVID-19 infection:

- Regardless of COVID-19 severity, anti-malarial therapies (HCQ/CQ), SSZ, MTX, LEF, immunosuppressants, non-IL-6 biologics, and JAK inhibitors should be stopped or held (M/H).
- For patients with severe respiratory symptoms, NSAIDS should be stopped (M). The panel demonstrated low consensus with regards to stopping NSAIDs in the absence of severe symptoms.
- In select circumstances, as part of a shared decision-making process, IL-6 inhibitors may be continued (M).

Reinitiating Treatment Following COVID-19:

- For patients with uncomplicated COVID-19 infections (characterized by mild or no pneumonia and treated in the ambulatory setting or via self-quarantine), consideration may be given to re-starting rheumatic disease treatments (e.g., DMARDs, immunosuppressants, biologics and JAK inhibitors) within 7 to 14 days of symptom resolution. For patients who have a positive PCR test for SARS-CoV-2, but are (and remain) asymptomatic, consideration may be given to re-starting rheumatic disease treatments (e.g., DMARDs, immunosuppressants, biologics and JAK inhibitors) 10 to 17 days after the PCR test is reported as positive (H).
- Decisions regarding the timing of reinitiating rheumatic disease therapies in patients recovering from more severe COVID-19-related illness should be made on a case-by-case basis (H).

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