Australian Rheumatology Association

**Advice for GPs and other Health Professionals caring for patients with autoimmune inflammatory rheumatic diseases (AIRD) in the COVID-19 (Coronavirus) pandemic**
**13 July 2021**

This document provides an update on the information published in June 2021.

The Australian Department of Health identified patients with AIRD as potentially vulnerable to COVID-19, hence they were included in Phase 1b of the National vaccine rollout which commenced on the 22 March 2021.

**What do we now know about patients with AIRD who have contracted COVID-19?**

- As of July 2021, COVID-19 infection has been reported in < 50 Australian patients with AIRD (https://rheum-covid.org/map).
- Current available evidence suggests that most people with AIRD recover from COVID-19.
- Factors associated with COVID-19 related death include general and disease-specific factors. This has been investigated in a study of 3729 patients with AIRD through the COVID-19 Global Rheumatology Alliance (https://rheum-covid.org/) recently published in Ann Rheum Dis (https://ard.bmj.com/content/early/2021/03/07/annrheumdis-2020-219498)
    - Older age, male sex, cardiovascular disease and chronic lung disease were associated with COVID-19-related death (in keeping with data from the general population)
    - Moderate/high disease activity, prednisolone >10mg daily, rituximab, sulfasalazine and some immunosuppressants were associated with COVID-19-related death. Methotrexate and tumour necrosis factor inhibitors were not shown to have a negative impact.
- Therefore, the priority should be to **maintain adequate disease control in patients with AIRD while minimising glucocorticoids.** Glucocorticoids have been associated with higher odds of hospitalisation.
- A number of medications used to treat rheumatic diseases, such as hydroxychloroquine, glucocorticoids (dexamethasone), tocilizumab and baricitinib have been trialled as treatments for severe COVID-19. Only dexamethasone and tocilizumab have been shown to be effective in the treatment of severe COVID-19 infections. Regardless, ALL patients on these medications should **take the same precautions as all members of the community.**
    - If patients with AIRD develop symptoms of any significant infection, they should contact their rheumatology team for specific advice. **Decisions to pause treatment should be made on a case-by-case basis.**

**What information should you consider in discussing COVID-19 vaccination with your patients?**

- **Patients with AIRD are recommended to receive the COVID-19 vaccination and they can have either the Astra Zeneca or the Pfizer vaccine in line with the current ATAGI guidelines; https://www.health.gov.au/resources/publications/covid-19-vaccination-atagi-clinical-guidance-on-covid-19-vaccine-in-australia-in-2021**
- Some people with AIRD who are younger than 60 years may prefer early vaccination with the AstraZeneca vaccine over delayed access to a different vaccine, particularly those who are:
    - at increased risk of exposure to COVID-19 (e.g., quarantine facility or Border Force staff, emergency healthcare workers, people planning to travel outside Australia, or those living in areas of known community transmission) *and*
    - at higher risk of poor COVID-19 outcomes (including those with active or severe AIRD, multiple comorbidities, and/or using immunomodulatory medications associated with a higher risk of severe COVID-19, such as rituximab and/or moderate to high doses of prednisolone)
- The Australian Government consent form asks whether patients are immunocompromised. Ticking "yes" does **not** mean patients cannot receive the COVID-19 vaccination.

https://www.health.gov.au/sites/default/files/documents/2021/04/covid-19-vaccination-consent-form-for-covid-19-vaccination-covid-19-vaccination-consent-form_1.pdf

- The ARA has produced an information sheet for patients with AIRD on the COVID-19 vaccination. This sheet can be found here; **https://rheumatology.org.au/downloads/20210706%20COVID-19%20vaccination%20patient%20information%2030Jun21.pdf**
- Following vaccination, people with AIRD should be aware that the risk of COVID-19 infection is reduced but not eliminated and that appropriate physical precautions (e.g., masks, physical distancing, hand hygiene) based on the current community risk should continue to be observed.
- There is a theoretical risk of disease flare following vaccination, so an appropriate mechanism for specialist management of flares should be in place.

**What about medication considerations around COVID-19 vaccination?**

- **Please refer to the Australian Clinician Guide for specific information on the use of immunomodulatory medications at the time of COVID-19 vaccination. https://drive.google.com/file/d/16uiV5Ug51NiuPi5m1ToIsXMfrhxbggFX/view**
- **The decision to hold any immunomodulatory medication should be individualised and discussed with the treating rheumatologist.**

**What about influenza and pneumococcal vaccination?**

- Influenza vaccination is recommended for everyone with AIRD. Whilst influenza vaccination does not protect against COVID-19, it is critical to protecting the health of Australians from influenza.
    - Influenza vaccination should be offered at least 1 week apart from COVID-19 vaccination.
- Pneumococcal vaccination status should be reviewed in appropriate patients
    - Medicare restrictions were modified for pneumococcal vaccination on 1 July 2020.

This advice is drawn from a number of resources including The British Society of Rheumatology, The Global Rheumatology Alliance, The Department of Health, Australia and is current as of 13 July 2021.