Australian Rheumatology Association

Advice for GPs and other Health Professionals caring for patients with Rheumatoid Arthritis, SLE and other autoimmune diseases in the COVID-19 crisis

It has been highlighted in the media that immunosuppressed people may be amongst the most severely affected should they become infected with this virus.

You should be aware that to date there have been **no data commenting on the outcomes of COVID-19 infection in patients with autoimmune inflammatory disease or taking DMARDs or biologic medications** (such as TNF inhibitors) so please consider the below information before advising patients.

For more information on this topic, read:
Winthrop K.L(2020) Who needs a Corona? Arthritis Rheumatol.
https://doi.org/10.1002/art.41260

Should patients cease their medication as a precaution?
NO. While some rheumatology patients may be considered 'high-risk' it is really important to counsel patients to continue anti-rheumatic, analgesic, anti-inflammatory, DMARD or biologic therapies. These are prescribed to manage symptoms and/or to reverse inflammation or immune dysregulation. Uncontrolled disease is a much greater risk than the treatments, due to increased inflammation and immunosuppression.

Is there any rheumatology-specific data on the impact of coronavirus to date?
Research is underway to explore the effectiveness of a number of rheumatic drugs in treating coronavirus. The Australian Rheumatology Association (ARA) has joined the COVID-19 Global Rheumatology Alliance to rapidly generate data specific to patients with rheumatic diseases and provide information back to doctors and patients about how these patients and those treated with rheumatology drugs fare if they develop COVID-19.

Specific medications:
NSAIDs: On 14 March 2020 the French Health Minister tweeted that that ibuprofen 'could be a factor in aggravating' infection in patients with COVID-19. The World Health Organization (WHO) initially recommended people with COVID-19 avoid taking ibuprofen for symptomatic relief; however, it retracted that advice days later. The recommendation has been dismissed by other regulatory agencies. Paracetamol is generally safer than ibuprofen, but to date there is no direct or clear evidence of harm or adverse events when ibuprofen (or any NSAID) is used in the setting of a COVID-19 infection. It is important that patients who use any NSAIDs (such as ibuprofen and naproxen) to treat their chronic diseases should not stop their treatment.

Hydroxychloroquine: Hydroxychloroquine is being trialled as treatment for those infected. **It is a trial so please only prescribe it for patients who require it for SLE, RA or other approved indications.** There is already a shortage. Inappropriate prescribing will mean those who need it cannot get it and risk a serious disease flare or the need to start prednisolone or more potent immunosuppression.

Prednisolone and other glucocorticoids: There are no specific data in COVID-19 infection but stopping abruptly might cause significant harm so is not recommended. However, commencing prednisolone or other glucocorticoids without a specific indication is not recommended as it may be associated with an increased risk of infection.

Methotrexate, leflunomide, and sulfasalazine: As there is currently no evidence that the use of these medications increases the risk of acquiring COVID-19 or developing severe disease if infected, the risk to patients of uncontrolled rheumatic disease outweighs any potential or theoretical benefit of avoiding immunomodulatory drugs.

TNF inhibition (adalimumab, etanercept, certolizumab, golimumab, infliximab): A small number of patients on TNFi have been infected but there are no reports of worsening, death, or adverse outcomes.

JAK inhibition (baricitinib, tofacitinib): The Lancet has reported that baricitinib may be a potential treatment for COVID-19 acute respiratory disease. Until more data emerge, the use of JAK inhibitors such as baricitinib or tofacitinib should be only for approved indications.

IL-6 Inhibitor (tocilizumab): It has been estimated that as of March 5, a total of 272 patients with severe COVID-19 lung disease have been treated with tocilizumab in the hope that blocking IL-6 will limit the cytokine release storm seen in severe respiratory cases. Outcomes of this approach are not yet clear and further studies are underway. Tocilizumab has not been suggested to prevent or cure COVID-19 itself; patients on tocilizumab should take the same precautions as all patients.

Other biologicals (abatacept, rituximab): There are no specific data in COVID-19 infection but stopping these medications may lead to uncontrolled rheumatic disease.

Should patients who become unwell with ANY infection cease their medication?
If patients develop symptoms of any significant infection, established practice should be followed and immunosuppressive therapy paused for the duration of the infection and until they feel well, in consultation with their rheumatology team. For those on glucocorticoids (steroids, prednisolone), the expectation is that treatment should not be stopped abruptly and advice should be sought from their treating team.

What precautions should patients be advised to take?
Avoidance of all non-essential contact with people is recommended. This includes

- working from home if possible
- avoiding public spaces
- avoiding unnecessary travel
- adhering to social distancing and hand washing
- using telehealth/phone to communicate with doctors where possible

What about vaccination?

- Flu vaccination when available (privately now, GP supply by April) and appropriate (optimally given late April or May)
- Consider pneumococcal vaccination in appropriate patients

Should patients who are immunosuppressed be offered alternative clinic appointments?
Patients should be advised to contact their rheumatologist to see if a telephone or video consultation is suitable. This will remove the need for patients to attend face-to-face appointments. Medicare has introduced new item numbers to support this. Biological assessments may be conducted remotely if the patient is stable. However, on occasions it may be clinically necessary for the patient to be seen face to face.

Is there any specific advice for health professionals that are considered part of high-risk groups, such as those with rheumatic conditions themselves?
Immunosuppressed healthcare workers should ensure that their line manager/clinical lead, occupational health and treating rheumatologist are all aware of their medication and scope of practice.

What about supply of medications?
Community pharmacies are in the process of enhancing their capacity to supply medication without patients coming to the premises. If patients are self-isolating/quarantining they can call their pharmacy to ask about this.

What about request for "just in case" medications?
GPs and HPs with prescribing capacity may be under pressure from patients or others to provide prescriptions for hydroxychloroquine, tocilizumab and/or baricitinib, mindful they are being investigated as possible treatments for COVID-19. These are trials. Please only prescribe for an approved indication. For many Australians, these are critical medicines, and an interruption to supply will result in significant adverse health impacts.

As more information becomes available, this document will be updated.

Versino1, 23 March 2020