Blood Monitoring and Prescribing for DMARDs during COVID-19 pandemic

Royal United Hospitals Bath NHS Foundation Trust

Where DMARD use has been successful and stable (> 12 months on treatment, and stable dose for > 6 weeks) consider **extending the monitoring interval to up to every 6 months**.

However, extending blood monitoring is not suitable if the patient has:

Recently started a DMARD
Poor renal function with CKD ≥ 3
Severe liver disturbance or abnormal liver results due to DMARDs within previous 3 months
Severe abnormal WBC results due to DMARDs within previous 3 months

For these patients; risk stratify the patient into one of the following groups (see table overleaf) and follow guidance below

High Risk
(Patients Shielding*)

Blood Tests

- Call Consultant Connect to discuss the frequency of blood tests required

Prescribing

- Prioritize for home delivery of prescriptions on a monthly basis

Intermediate Risk
(Patients Self Isolating/social distancing*)

Blood Tests

- Follow usual monitoring guidance as far as able**. Call Consultant Connect to discuss if required

Prescribing

- Consider home delivery of prescriptions on a monthly basis if no other safe means of collecting medicines

Lower Risk
(Patients Social Distancing*)

Blood Tests

- Can continue to have blood tests as clinically indicated** whilst adhering to social distancing advice

Prescribing

- Continue monthly prescriptions as per normal

If patients develop symptoms of any 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 steroids, the expectation is that treatment should not be stopped abruptly and advice should be sought from their treating team.

*Links to advice on shielding, self isolation and social distancing are available at www.versusarthritis.org

** **Blood monitoring guidelines for DMARDs under normal circumstances;** https://www.ruh.nhs.uk/For_Clinicians/departments_ruh/Rheumatology_and_Therapies/documents/DMARDs_Guidance_for_GPs.pdf

KEY (cumulative score)

Score of 3 or more (high risk): patients to shield

Score of 2 (intermediate risk): patients to self-isolate or maintain social distance at their discretion

Score of 1 or less (low risk): patients to maintain social distance

Risk Factor	Score
Corticosteroid dose of ≥20mg (0.5mg/kg) prednisolone (or equivalent) per day for more than four weeks	3
Corticosteroid dose of ≥5mg prednisolone but <20mg (or equivalent) per day for more than four weeks	2
Cyclophosphamide at any dose orally or IV within last six months	3
Interstitial Lung Disease or Pulmonary Hypertension	3
One immunosuppressive medication*, biologic/monoclonal** or small molecule immunosuppressant***	1
Two or more immunosuppressive medication*, biologic/monoclonal** or small molecule immunosuppressant***	2
Any one or more of these: age >70, Diabetes Mellitus, pre-existing lung disease, renal impairment, history of ischaemic heart disease, hypertension,	1
Hydroxychloroquine, Sulfalsalazine alone or in combination	0
History of connective tissue disease or systemic vasculitis	3

- Immunosuppressive medications include: Azathioprine, Leflunomide, Methotrexate, Mycophenolate (mycophenolate mofetil or mycophenolic acid), ciclosporin, Tacrolimus, Sirolimus. It does **NOT** include Hydroxychloroquine or Sulphasalazine, either alone or in combination.
- ** Biologic/monocolonal includes: Rituximab within last 12 months; all anti-TNF drugs (etanercept, adalimumab, infliximab, golimumab, certolizumab and biosimilar variants of all of these); Tociluzimab; Abatacept; Belimumab; Anakinra; Seukinumab; Ixekizumab; Ustekinumab; Sarilumumab; Canakinumab
- *** Small molecules includes: all JAK inhibitors – baracitinib, tofacitinib etc

How do I manage patients on long-term steroids at risk of adrenal suppression in the COVID19 Pandemic ?

This guidance applies to any patient who has been taking 5mg prednisolone or more for four weeks or longer, as this may cause adrenal insufficiency.

As noted in the British National Formulary, adrenal insufficiency due to steroid therapy can persist even after a patient has tapered their prednisolone dose below 5mg, so many rheumatology patients currently taking <5mg prednisolone are also at risk of adrenal insufficiency

Patients with adrenal insufficiency need to temporarily increase their steroid dose if they have any significant intercurrent infection. Patients with COVID-19 may have high fever or other systemic symptoms for many hours of the day. In COVID-19, therefore, the standard advice to double the prednisolone dose in the event of significant intercurrent illness may not be sufficient. This can be applied to rheumatology patients as follows:

Patients on 5-15 mg prednisolone daily should take 10 mg prednisolone every 12 hours
Patients on oral prednisolone >15 mg should continue their usual dose but take it split into two equal doses of at least 10 mg every 12 hours
Patients with COVID-19 may have large insensible water losses, and should be advised to drink plenty of fluids especially if they may have adrenal insufficiency
Patients can be issued with the new NHS emergency steroid card which signposts healthcare providers to the latest guidance on management of adrenal crisis