NICE National Institute for
Health and Care Excellence

COVID-19 rapid guideline: rheumatological autoimmune, inflammatory and metabolic bone disorders

NICE guideline

Published: 3 April 2020

www.nice.org.uk/guidance/ng167

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

Overview

The purpose of this guideline is to maximise the safety of children and adults with rheumatological autoimmune, inflammatory and metabolic bone disorders during the COVID-19 pandemic, while protecting staff from infection. It also enables services to make the best use of NHS resources.

This guideline is for:

- health and care practitioners

- health and care staff involved in planning and delivering services

- commissioners.

The recommendations bring together:

- existing national and international guidance and policies

- advice from specialists working in the NHS from across the UK. These include people with expertise and experience of treating patients for the specific health conditions covered by the guidance during the current COVID-19 pandemic.

NICE has developed these recommendations in direct response to the rapidly evolving situation and so could not follow the standard process for guidance development. The guideline has been developed using the interim process and methods for developing rapid guidelines on COVID-19. The recommendations are based on evidence and expert opinion and have been verified as far as possible. We will review and update the recommendations as the knowledge base and expert experience develops.

1 Communicating with patients and minimising risk

1.1 Communicate with patients and support their mental wellbeing, signposting to charities and support groups (such as ARMA, which has a list of relevant organisations, and NHS Volunteer Responders) where available, to help alleviate any anxiety and fear they may have about COVID-19.

1.2 Minimise face-to-face contact by:

- cutting non-essential face-to-face consultations

- offering telephone or video consultations

- contacting patients via text message or email

- making use of departmental pages on local NHS trust websites

- using rheumatology department advice services, including out-of-hours services, and thinking about a shared approach with other NHS trusts

- using alternative ways to deliver medicines, such as postal services, NHS volunteers or drive through pick-up points

- expanding community-based blood monitoring services, where possible.

1.3 Advise patients to contact:

- NHS 111 by phone or via the website for advice on COVID-19

- their rheumatology team about any rheumatological medicines issues or if their condition worsens (or NHS 111 or primary care services, if this is not possible).

1.4 Tell patients who still need to attend services to follow relevant parts of UK government guidance on social distancing for everyone in the UK or UK government guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19.

2 Patients not known to have COVID-19

2.1 If patients have to attend the rheumatology department, ask them to come without a family member or carer if they can, to reduce the risk of contracting or spreading the infection. Encourage them to use their own transport, and to travel alone to the department whenever possible. Ask that children are accompanied by only 1 parent or carer.

2.2 Minimise a patient's possible exposure to infection while at the hospital by:

- encouraging them not to arrive early

- texting them when staff are ready to see them, so that they can wait outside the building, for example, in their car

- providing a 'clean route' through the hospital to the department

- reducing, and ideally eliminating, the time patients spend in waiting areas through careful scheduling

- delivering treatment promptly

- ensuring prescriptions are dispensed rapidly.

3 Patients known or suspected to have COVID-19

3.1 When patients with known or suspected COVID-19 have been identified, follow appropriate UK government guidance on infection prevention and control. This includes recommendations on patient transfers, and options for outpatient settings.

3.2 In patients known or suspected to have COVID-19:

- continue hydroxychloroquine and sulfasalazine

- do not suddenly stop prednisolone

- only give corticosteroid injections if the patient has significant disease activity and there are no alternatives, and refer to NHS England's clinical guide on the management of patients with musculoskeletal and rheumatic conditions on corticosteroids.

- temporarily stop other disease-modifying antirheumatic drugs, JAK inhibitors and biological therapies, and tell them to contact their rheumatology department for advice on when to restart treatment.

3.3 If COVID-19 is later diagnosed in a patient not isolated from admission or presentation, follow UK government guidance for health professionals.

4 Treatment considerations

4.1   Be aware that patients having immunosuppressant treatments may have atypical presentations of COVID-19. For example, patients taking prednisolone may not develop a fever, and those taking interleukin-6 inhibitors may not develop a rise in C-reactive protein.

4.2   If a patient not previously known or suspected to have COVID-19 shows symptoms at presentation, follow UK government guidance on investigation and initial clinical management of possible cases. This includes information on testing and isolating patients.

4.3   Discuss with each patient the benefits of treatment compared with the risks of becoming infected. Think about whether any changes to their medicines are needed during the current pandemic, including:

- dosage

- route of administration

- mode of delivery.

    Encourage and support shared care, by helping patients to carry out elements of their own care.

4.4   When deciding about treatments, use tables 1 and 2 in NHS England's clinical guide on the management of rheumatology patients. This includes a list of patients who are at risk of infection because of the medicines they are taking and information about risk grading.

4.5   Think about how treatment changes will be delivered and what resources are available. Be aware that some homecare drug delivery services are not accepting new referrals, in which case the department would need to organise this.

Non-steroidal anti-inflammatory drugs

4.6   Advise patients taking a non-steroidal anti-inflammatory drug for a long-term

condition such as rheumatoid arthritis that it does not need to be stopped.

Corticosteroids

4.7   Advise patients taking prednisolone that it should not be stopped suddenly.

4.8   Only use methylprednisolone for treating major organ flares. Think about using oral corticosteroids and refer to NHS England's clinical guide on the management of patients with musculoskeletal and rheumatic conditions on corticosteroids.

Biological treatments

4.9   Assess whether patients having intravenous treatment can be switched to subcutaneous treatment (for example, tocilizumab, abatacept, belimumab).

4.10   Assess whether patients having infliximab can be switched to an alternative subcutaneous tumour necrosis factor inhibitor.

4.11   Assess whether maintenance treatment with rituximab can be reduced to 1 pulse or the duration between treatments increased.

Immunoglobulins

4.12   Assess whether the frequency of intravenous immunoglobulins can be reduced in patients attending day-care services in line with NHS England's clinical guide on the management of patients requiring immunoglobulin treatment.

Bisphosphonates and denosumab

4.13   Do not postpone treatment with denosumab.

4.14   Treatment with zoledronate can be postponed for up to 6 months.

Treatments for digital ulcer disease

4.15   Ensure that patients having intravenous prostaglandins (for example, iloprost, epoprostenol) have had the maximum dose of sildenafil. Assess whether they

can be switched to bosentan.

5 Drug monitoring

5.1 Assess with each patient whether it is safe to increase the time interval between blood tests for drug monitoring, particularly if 3-monthly blood tests have been stable for more than 2 years.

5.2 Patients starting a new disease-modifying antirheumatic drug should follow recommended blood monitoring guidelines. When this is not possible, they should contact the relevant specialist for advice.

5.3 Think about pooling drug monitoring resources between local organisations.

6   Modifications to usual care

6.1   Make policy decisions about modifications to usual care at an organisational level. Refer to:

- table 3 in NHS England's clinical guide on the management of rheumatology patients, which includes information on what should be stopped or continued as things escalate

- the British Society for Rheumatology's COVID-19 guidance for rheumatologists, which includes a risk stratification guide for identifying patients with rheumatological disorders for shielding.

6.2   Only continue core services, including:

- rheumatology department advice lines (for general rheumatology, connective tissues disease and metabolic bone)

- essential parenteral day-case treatment

- blood tests for drug monitoring

- on-call services for urgent patient review (both new and follow up)

- delivery and support for patients on new injectable treatments.

6.3   Maintain a robust on-call service for cross-consultant referrals that is available all the time, teaming up with other NHS trusts if necessary.

6.4   In tertiary centres, maintain specialised rheumatology networks and virtual multidisciplinary team meetings to discuss the management of complex disorders and to ratify high-cost drug use.

Primary care and the community

6.5   Use rheumatology department advice lines, run by staff with appropriate knowledge, to provide professional advice to primary care and community colleagues about all patients. If available, use an electronic advice and guidance service for GPs.

6.6   Prioritise urgent and emergency musculoskeletal referrals to secondary care in line with NHS England's clinical guide on urgent and emergency musculoskeletal conditions requiring onward referral.

6.7   In musculoskeletal services, prioritise rehabilitation for patients who have had recent elective surgery or a fracture, and for those with acute or complex needs (including carers). Focus on enabling self-management in line with NHS England's guide on COVID-19 prioritisation within community health services.

Outpatients

6.8   For urgent new referrals from primary care for suspected inflammatory arthritis, suspected autoimmune connective tissue diseases and vasculitis (including giant cell arteritis), offer a phone or virtual consultation followed by a face-to-face appointment after asking about COVID-19 symptoms.

6.9   For urgent follow ups (such as for ongoing and new flares, and for treatment adjustment after monitoring), think about using phone or virtual consultations followed by a face-to-face appointment, if needed, after asking about COVID-19 symptoms.

Day care

6.10   Prioritise day-case attendance based on the urgency of a patient's condition (for example, for new or ongoing flares, relapses, intravenous induction treatment).

Inpatients

6.11   Maintain rheumatology ward cover, and an out-of-hours on-call service if possible, to:

- provide advice on immunosuppressive drugs

- carry out assessments of rheumatological and COVID-19 disease status

- enable early discharge.

7 Healthcare workers

7.1 All healthcare workers involved in receiving, assessing and caring for patients who have known or suspected COVID-19 should follow UK government guidance for infection prevention and control. This contains information on using personal protective equipment (PPE), including visual and quick guides for putting on and taking off PPE.

7.2 If a healthcare professional needs to self-isolate, ensure that they can continue to help by:

- enabling telephone or video consultations, and attendance at virtual multidisciplinary team meetings

- identifying patients who are suitable for remote monitoring and follow up, and those who are vulnerable and need support

- carrying out tasks that can be done remotely, such as entering data.

7.3 Support staff to keep in touch as much as possible, to support their mental wellbeing.

7.4 Provide all staff with visible leadership and supportive messaging, to maintain morale.

7.5 Take account of the information on the NHS Employers website about good partnership working and issues to consider when developing local plans to combat COVID-19.

ISBN: 978-1-4731-3762-2