Egyptian Society of Rheumatic Diseases (ESRd) Viewpoints for Management of Rheumatic Musculoskeletal Diseases (RMDs) in Coronavirus disease 2019 (COVID-19) Era

I- Viewpoints regarding behavior change for the patients:

1. Frequent hand washing with water and soap for at least 20 seconds
2. Avoiding touch face (especially mouth, nose, and eyes)
3. Use ethyl alcohol gel outside home for hands, but dirty hands should be cleaned by washing with water and soap
4. Keep distance 2 meter from others
5. Wear mask in public areas
6. Avoid crowded places. Stay home as much as possible
7. Advice people around patients to follow good respiratory hygiene (including covering mouth and nose with bent elbows or tissue during cough/sneeze).

II- Viewpoints regarding behavior change for the health-care providers (rheumatologists, nurses, and staff):

1. Use Personal Protective Equipment (PPE) at all working times according to Standard precautions for infection control and risk

assessment. This includes medical surgical mask, gloves, face shield and gown.

2. Encourage telehealth service when feasible (online consultations, video/chat applications e.g. Zoom, Skype, WhatsApp, …etc).
3. Postpone follow-up visits for stable patients.
4. Prescribe oral, SC, IM over IV medications whenever possible to avoid hospitalization.
5. Extend monthly refill of medications to longer intervals for chronic patients when possible.
6. Autoimmune rheumatic disease patients should be supported with reports with their condition and their medications to use when needed (e.g., to work from home).

II- Viewpoints regarding management of rheumatic patients:

A. <u>Stable non-infected patients:</u>

1. Patients should not stop or reduce their rheumatic medications (immunosuppressive and/or Disease-modifying anti-rheumatic drugs (DMARDs) for fear of COVID-19 infection.
2. Nonsteroidal anti-inflammatory drugs (NSAIDs) do not alter the course of COVID-19. You may prescribe or maintain it when needed.
3. Hydroxychloroquine (HCQ) should not be discontinued ever in all patients already receiving. In market shortage, temporarily decrease the dose to 1 tablet/day to every other day. When unavailable shift to another feasible conventional synthetic DMARDs (csDMARDs). Hydroxychloroquine initiation is encouraged in all new SLE patients. For other diseases, ESRd cannot give formal advice in view of unconfirmed effects of the drug on COVID-19.

4. Continue all other biologic DMARDs, and JAK inhibitors. If possible, postpone IV administered drugs to minimize hospital admission.
5. Consider tapering of glucocorticoids (GC) in stable disease to lowest possible dose.
6. Angiotensin converting enzyme (ACE) inhibitors and Angiotensin II receptor blockers (ARBs) are continued per standard of care.

B. Stable patients with RMDs with exposure to COVID-19 infected persons :

1. Stop immediately all csDMARDs, immunosuppressants, biologics and JAK inhibitors. Patients can continue HCQ or IL-6 inhibitor. Do PCR for COVID-19, if it is negative and patients are respiratory free, resume the medications.
2. Continue long-term GC therapy at the same dose.

C. Stable patients with RMDs tested positive for COVID-19:

3. Stop immediately all csDMARDs, immunosuppressants, biologics and JAK inhibitors. Patients can continue HCQ or IL-6 inhibitor.
4. Continue long-term GC therapy at the same dose.
5. Stop NSAIDs in those with severe respiratory symptoms.

D. Active patients tested positive COVID-19:

1. Mild to moderate flare: HCQ or sulfasalazine (SSZ) only. NSAIDs may be used in the absence of COVID-19 induced severe respiratory symptoms.
2. Consider intra-articular steroids injection for monoarthtiris.
3. Severe flare: admission of patients. Use IL-6 inhibitor if an option. Keep on HCQ, SSZ and/or low dose GCs.


The Egyptian Society of Rheumatic diseases
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