Response to: ‘Case series of acute arthritis in COVID-19 admission’ by López-González et al

We read the comment on our article by López-González et al with great interest.1,2 The authors detail the presentation of four cases of acute arthritis in patients hospitalised with COVID-19 and undergoing gout (three) or recurrent arthritis of unknown origin (one case). Although we await further reports, there have been anecdotes of newly diagnosed inflammatory arthritis in the context of COVID-19 infection, perhaps representing either a viral-associated arthritis or a reactive arthritis.3,4 However, as the authors note, common causes of acute inflammatory arthritis must continue to be considered in the differential diagnosis—these include crystal-associated arthritis, such as gout or pseudogout. Acute illnesses, including infection, are well-established risk factors for gout and pseudogout flares; inpatient gout flares are known to complicate admissions for heart failure, pneumonia and acute kidney injury.5 These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury. These comorbidities are either known to complicate admissions for heart failure, pneumonia and acute kidney injury.

The thorough workup completed by the authors highlights some of the current gaps in severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) testing methods. While reverse transcription (RT)-PCR testing was negative in all three of the synovial fluid samples in these patients with documented COVID-19 infection from nasopharyngeal swab, no molecular testing method has been validated yet to detect SARS-CoV-2 in synovial fluid. Thus, the clinical significance of the synovial fluid cultures and RT-PCR results is currently unknown. Despite these uncertainties, we commend the authors’ efforts in providing the first report of SARS-CoV-2 nucleic acid testing in synovial fluid.

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