

COVID-19 in patients with rheumatological diseases treated with anti-TNF

We have read with great interest the recent article from Silva *et al* about the clinical course of COVID-19 in rheumatic disease.¹ In this matched cohort study of patients with COVID-19 infection, although the authors found a similar proportion of symptoms, risk of hospitalisation and mortality between patients with and without rheumatic disease, there was a threefold higher odds of intensive care admission/mechanical ventilation in the former. The authors considered that certain immunosuppressive medications could explain the higher risk of respiratory complications. However, the risk associated with severe infections differs among immunosuppressive medications; therefore, the analysis of clinical disclosures must be individualised according to therapeutic class.²⁻⁴ In the study by Silva *et al*, there was no detailed comparison of the clinical behaviour of patients using different immunosuppressive medications. There is a record of corticosteroid use in 37 of 52 patients, probably combined with the use of other immunosuppressive medications.¹ The use of corticosteroids in patients with rheumatological disease has been associated with a higher risk of infections for different aetiological agents, including respiratory infection.² Studies in patients infected with coronavirus and influenza virus treated with corticosteroids show a higher risk of complications and deaths.⁵

In the study, the second most common group of drugs used by the patients was biological disease-modifying antirheumatic drugs, with 60% of the patients using this therapy, and among them, a tumour necrosis factor (TNF) inhibitor was the most used. Patients with rheumatological diseases using immunosuppressive drugs, including biological therapy, have been considered to potentially be an at-risk group for COVID-19 infection and for complications.⁶ Some medical specialty societies have recommended postponing the start or extending the use of biological therapy, including anti-TNF treatment, in areas of sustained community circulation of COVID-19, though the use of interleukin 6 (IL-6) inhibitors is considered safer.^{7,8}

Recently, there have been case reports of patients infected with COVID-19 who were using TNF inhibitors and experienced no respiratory complications or death.⁹⁻¹¹ In the clinical practice of this group, we reported three patients with rheumatological diseases using anti-TNF who were infected with severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2). One of the patients had been diagnosed with Behçet's disease 8 years prior, with a history of several manifestations of vasculitis, including multiple painful and recurrent oral ulcers, recurrent abdominal pain and distension, peripheral venous thrombotic phenomena, neurological manifestations and human leukocyte antigen (HLA)-B51 positivity. Past use of azathioprine 100 mg/day, oral anticoagulant and mycophenolate sodium was recorded. Treatment with infliximab started 9 months prior due to a neurological condition. The second patient had ankylosing spondylitis (AS) and had used golimumab. The third patient had rheumatoid arthritis for 12 years and had used infliximab for 4 years.

The patients had a mild form of COVID-19, not presenting with dyspnoea and not requiring hospitalisation; outpatient follow-up was sufficient. They were treated only with symptomatic medication (paracetamol). None of the three patients used antivirals or hydroxychloroquine, and only the patient with AS was prescribed azithromycin. All had taken regular doses of anti-TNF before the COVID-19 infection, and the patient with Behçet's disease used it 1 day before the onset of symptoms.

Table 1 Demographic data, clinical characteristics and treatment of the patients with confirmed and clinical COVID-19

| | Patient 1 | Patient 2 | Patient 3 |
|---|----------------------------|----------------------|-------------------------------------|
| Diagnosis | Behçet's disease | Rheumatoid arthritis | Ankylosin spondylitis |
| Age, years | 40 | 60 | 65 |
| Sex | F | M | F |
| Comorbidities | – | Hypertension | Hypertension Hashimoto's disease |
| Disease status at last visit | Remission | Remission | Remission |
| Diagnosis of the disease in years | 8 | 12 | 4 |
| Use of corticosteroids | No | No | No |
| Biological therapy: anti-TNF | Infliximab | Infliximab | Golimumab |
| Date of the last infusion of anti-TNF | 03/16/2020 | 03/24/2020 | 03/31/2020 |
| Symptom onset date— COVID-19 | 03/17/2020 | 04/31/2020 | 04/17/2020 |
| Time interval between infusion and symptom onset in days | 1 | 38 | 17 |
| RT-PCR COVID-19 (data) | 03/24/2020 | 05/11/2020 | 04/22/2020 |
| Therapy instituted during treatment | Symptomatic medications | Azithromycin | Symptomatic medications |
| Symptoms (duration of symptoms in days) | | | |
| Fever | No | Yes (1) | No |
| Maximum temperature | 37.2 | 38.5 | 36.5 |
| Non-productive cough | No | Yes (4) | Yes (10) |
| Sputum production | No | No | No |
| Rhinorrhoea | Yes (1) | No | No |
| Nasal congestion | Yes (1) | Yes (2) | Yes (8) |
| Sore throat | No | No | Yes (2) |
| Anorexia | Yes (2) | No | No |
| Fatigue | Yes (4) | No | Yes (12) |
| Myalgia | No | Yes (2) | Yes (5) |
| Arthralgia | No | No | No |
| Anosmia | Yes (9) | No | Yes (7) |
| Dysgeusia | Yes (4) | No | Yes (8) |
| Headache | Yes (2) | Yes (2) | Yes (2) |
| Diarrhoea | No | No | Yes (2) |
| Nausea | Yes (3) | No | No |
| Vomiting | No | No | No |
| Chest X-ray or CT scan | Not done | Not done | Not done |


Twenty-one days after overcoming the resolution of symptoms, they were allowed to continue the anti-TNF treatment (table 1).

Since anti-TNF has been associated with an increased risk of infections, often severe, patients using anti-TNF have been considered a high-risk group for COVID-19 infection.^{7,8} Despite the increased risk associated with anti-TNF, infections are selective, likely involving some types of viral intracellular pathogens (hepatitis B, varicella zoster, human polyomavirus JC virus) and bacteria (*Listeria monocytogenes* or *Salmonella* spp), especially granulomatous infections such as tuberculosis, which mechanism for combating infection is partially dependent on TNF, with no evidence at the moment of risk for infection by a coronavirus, including SARS-CoV-2.⁴

A cytokine storm has been associated with the immunopathogenesis of COVID-19 infection, including the participation of TNF, which has pro-inflammatory activities that can lead to extensive tissue damage, including pulmonary injury and shock by vascular leakage.^{12,13} In vitro studies have shown that TNF

facilitates the SARS-CoV-2 interaction with ACE2, which is involved in viral entry.¹⁴ Increased levels of cytokines can be a risk factor for severe forms of the disease. In a study conducted with 548 COVID-19 patients, Li *et al* demonstrated that increased levels of IL-2R, IL-6, IL-10 and TNF- α cytokines were significantly higher in critically ill patients than in non-critically ill patients (all $p < 0.01$).¹⁵

Rheumatological diseases may be associated with an increased risk of severe infections associated with underlying diseases, chronic inflammatory processes and the use of immunosuppressive drugs. However, the case reports have shown a mild form of the disease, and the use of anti-TNF seems to have had a protective effect on the evolution to severe forms, thereby preventing the damaging effects of the high levels of cytokines associated with the immunopathogenesis of infection. In addition to having a mild form of infection, the reported cases did not experience recurrence of their rheumatological disease during the COVID-19 infection. Further clinical trials may help define the real benefit of anti-TNFs and their applicability to reduce the incidence of severe forms of COVID-19.

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