

COVID-19 Global Rheumatology Alliance Registry, anti-IL-6 therapy, shared decision-making and patient outcomes. Response to: 'Correspondence on 'Characteristics associated with hospitalisation for COVID-19 in people with rheumatic disease: data from the COVID-19 Global Rheumatology Alliance physician-reported registry' by Gianfrancesco *et al*. Compassionate use of tocilizumab in severe COVID-19 with hyperinflammation prior to advent of clinical trials – a real-world district general hospital experience' by Khan *et al*, 'Comment on 'Characteristics associated with hospitalisation for COVID-19 in people with rheumatic disease: data from the COVID-19 global rheumatology alliance physician-reported registry' by Gianfrancesco M *et al*' by Andreica *et al* and 'COVID-19 outcomes in patients with systemic autoimmune diseases treated with immunomodulatory drugs' by Ansarin *et al*

We thank Dr Khan and colleagues, Dr Ansarin and colleagues and Dr Andreica and colleagues for their correspondence in relation to our paper.¹⁻⁴ The reported experience of Dr Khan and colleagues² in using anti-interleukin (IL)-6 therapy in the treatment of COVID-19 is interesting, and although there has been much positive observational data reported on the value of anti-IL-6 therapy in COVID-19, including in this journal,⁵ preliminary reports from two randomised trials have not shown benefit.^{6,7} When further data are published on anti-IL-6 therapy in treating COVID-19, we can hopefully understand better if this therapy will have a place. Detailed cytokine analysis of 1484 patients with COVID-19 found that IL-6 and tumour necrosis factor (TNF) were independent and significant predictors of poor outcome.⁸ Therefore, TNF also seems to play an important role in severe COVID-19 and our paper reported a reduced odds of hospitalisation in those taking anti-TNF therapy compared with those not receiving any disease modifying anti-rheumatic drugs (DMARDs).¹ Efforts are underway to assess whether anti-TNF treatment is an effective therapy in COVID-19 in the form of the UK-based CATALYST trial (ISRCTN40580903).⁹

Dr Andreica and colleagues report that 80% of patients undertook a shared decision with their physician about the management of their rheumatic disease during the early part of the pandemic.³ This provides reassurance that patients are choosing to consult their doctor about potential changes to their rheumatic therapy. Changes to therapy may or may not reduce risk of poor outcomes from COVID-19 and may expose the patient to risks of disease flare, new disease complications or Addisonian crisis; therefore, doing this in conjunction with a doctor is the best way to ensure that all the consequences of altering therapy are considered and weighted appropriately.

Dr Ansarin and colleagues report the outcome of 30 patients with autoimmune disease treated with immunomodulatory medications.⁴ It is reassuring that their outcomes do not differ from

the comparison group of 381 patients also detailed in the report. D'Silva and colleagues also recently examined 52 patients with rheumatic disease and 104 comparison patients and found no difference in hospitalisation, length of stay or death. However, they did find an increased rate of intensive care admission/mechanical ventilation in patients with rheumatic disease.¹⁰ As further data are published, we can further understand the risk profile of patients with rheumatic disease with COVID-19.

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