Should patients starting biologics be screened for COVID-19?

We read with great interest the European League against Rheumatism (EULAR) provisional guidelines regarding rheumatic and musculoskeletal disease management during the COVID-19 pandemic recently published by Landewé *et al*.[1] While the COVID-19 pandemic continues across the world, rheumatology care has been enormously impacted. In the strive to adapt, telemedicine and telehealth have taken a predominant role in our everyday practice. Additionally, our treatment schemes have changed and sometimes have been deferred. Initial questions from rheumatologists—such as 'are my patients with rheumatic diseases at higher risk of COVID-19?' and 'should I stop their anti-rheumatic treatment (biologic or not) during the COVID-19 pandemic?'—slowly get answered as evidence continues to accumulate.

However, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is here to stay for a long time, and a new question arises as outpatient rheumatology clinics and infusion centres are slowly reopened: should patients starting biologics be screened for COVID-19 too? Testing for SARS-CoV-2 before initiating biological therapy was not addressed in the recent guidelines published by the EULAR and the American College of Rheumatology for the management of adults with rheumatic diseases during the COVID-19 pandemic.[1 2]

Patients starting biological therapy are routinely screened for infections (testing for tuberculosis, HIV, hepatitis B and hepatitis C is a standard of care), and gastroenterologists have advocated for testing for SARS-CoV-2 before initiating biological therapy in patients with inflammatory bowel disease.[3]

So far, it appears the incidence or risk of contracting SARS-CoV-2 infection is similar between patients with rheumatic diseases and the general population.[1] Regarding COVID-19 complications, such as the risk of an intensive care admission or initiation of mechanical ventilation, evidence has been contradictory probably due to the heterogeneous samples, and different populations and treatments.[4]

The use of biological and targeted disease-modifying antirheumatic drugs (b/tsDMARDs) was associated with a lower rate of hospitalisation in the COVID-19 Global Rheumatology Alliance physician registry, which reported 600 cases of patients from 40 countries with rheumatic diseases and COVID-19 diagnosis.[5] Additionally, a study of 41 patients from Spain with rheumatic diseases treated with b/tsDMARDs did not find a higher risk of complications or mortality compared with the general population.[6] Whether these findings apply to those asymptomatic carriers or mildly symptomatic patients infected with COVID-19 in which biological therapy is being started remains unknown. We should analyse the current evidence carefully and recognise its limitations.

Advantages for testing include identifying asymptomatic carriers or mildly symptomatic patients for early isolation and vigilance and avoiding exposure of nurses administrating biological medication at home or personnel from infusion centres. Disadvantages include increased cost and lack of data regarding additional risk associated with b/tsDMARDs therapy. We believe that a pragmatic approach during these uncertain times is adequate and that screening for SARS-CoV-2 before biological therapy is reasonable.

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Contributors JAC-dG, RIA-R and DAG-D conceived the idea, wrote the manuscript and approved the final version.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, conduct, reporting or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Cardenas-de la Garza JA, Arvizu-Rivera RI, Galarza-Delgado DA. *Ann Rheum Dis* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/annrheumdis-2020-218437

Received 25 June 2020
Accepted 27 June 2020

Ann Rheum Dis 2020;**0**:1. doi:10.1136/annrheumdis-2020-218437

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