Response to ‘Impact of COVID-19 pandemic on hospitalisation of patients with systemic lupus erythematosus (SLE): report from a tertiary lupus centre during the peak of the pandemic’ by Chuah et al

We thank Chuah et al1 for their interest in our study reporting on the course of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) disease 2019 (COVID-19) in a case series of patients with systemic lupus erythematosus (SLE) under long-term treatment with hydroxychloroquine.2 Chuah et al point to an indirect consequence of the COVID-19 pandemic, the reluctance of patients to come to the hospital because of the fear to contract COVID-19 that is reinforced by the awareness of the contagious nature of SARS-CoV-2. The experience of Chuah et al is instructive in this regard. The authors observed a decline of 65.4% in the SLE hospitalisation rate in their medical centre during the containment period, as compared with the same period in 2019. Moreover, five out of the six new patients with SLE presented to the hospital long after the first clinical manifestations. This finding should be put into perspective with the increase in the number of in-hospital deaths of patients with SLE related to infections apparently independent of SARS-CoV-2, which suggests a harmful increase in the diagnostic delay and/or in the medical care of these patients. We would like to suggest that the authors do not limit their comparison with the number of hospitalisations in 2019 but rather extend their study to the previous years to give more weight to their observations, given the important statistical variability of small sample size. We also do acknowledge that our case series does not provide any information in this area.

Since the start of the pandemic, several other issues have emerged regarding patients with SLE. The first difficulty was the shortage, or the fear of shortage, of antimalarial drugs, commonly used in the treatment of these patients, due to their off-label use to treat COVID-19.3–4 However, given that these drugs have not yet been shown to be effective against SARS-CoV-2 infection, their prescription rate will most likely decrease and patients with SLE will again have unrestricted access to antimalarial medication for continued treatment of their disease. The second problem for patients with SLE is the question whether they are more susceptible to infection with SARS-CoV-2, and if infected, whether they progress to a more severe form of the disease with a poorer outcome. Although the prevalence of confirmed or suspected SARS-CoV-2 infection has been reported to range from 4% to 8% in patients with SLE in regions severely impacted by the pandemic such as Northern Italy, Belgium and New York City,5–7 it is almost impossible to proceed to a reliable comparison with the prevalence of the infection in the general population. Yet, studies of small or larger case series of patients with SLE and COVID-19 have suggested that associated comorbidities such as arterial hypertension, diabetes, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure and obesity might be risk factors for progression to severe form of COVID-19, similar to what has been observed in the general population.6–8,11 However, whether patients with SLE on glucocorticoids and/or immunosuppressants are at an increased risk for hospital admission during the course of SARS-CoV-2 infection, as has been suggested in immune-mediated inflammatory disease in general,12–14 is unclear to date and further studies are needed to identify additional specific risk factors for severe COVID-19 in SLE. Third, the pursuit of individualised clinical and laboratory monitoring, in addition to the renewal of drug prescriptions, has been challenged in many countries by the population confinement, as well as the restructuring of their usual medical team and/or facilities toward the care of patients with COVID-19. It is probable that the use of telemedicine, as pointed out by several authors, has made it possible to not considerably disrupt the monitoring of disease and consequently prevent and/or detect certain complications for chronic patients already in the outpatient circuit.12,15 However, teleconsultation is of limited value in terms of laboratory screening for, often clinically asymptomatic, abnormalities, such as proteinuria, elevated serum creatinine, thrombocytopenia and anaemia, all of which are common manifestations of SLE. Teleconsultation is also inadequate for new patients and for the diagnosis of acute events such as cardiovascular or infectious complications for which urgent treatment is often needed. Unfortunately, these complications are very frequent during SLE and it is important for medical teams to reflect on this issue. With respect to home proteinuria screening, the use of urine dipsticks may be practical value. The improvement of rapid and direct lines of communication between patients and physicians that, in the event of unusual symptoms, will allow the latter to convince reluctant patients to be hospitalised when the medical situation requires it, is also probably one of the solutions to these recurrent problems.

Alexis Mathian, Zahir Amoura
Sorbonne Université, Assistance Publique–Hôpitaux de Paris, Groupement Hospitalier Pitié–Salpêtrière, French National Referral Center for Systemic Lupus Erythematosus, Antiphospholipid Antibody Syndrome and Other Autoimmune Disorders, Service de Médecine Interne 2, Institut E3M, Inserm UMR5, Centre d’Immunologie et des Maladies Infectieuses (CIMI-Paris), Paris, France

Correspondence to Dr Alexis Mathian, Internal Medicine, University Hospital Pitié Salpêtrière, Paris 75651, France; alexis.mathian@aphp.fr

Handling editor Josef S Smolen

Contributors AM and ZA wrote the manuscript.

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, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Commissioned; internally peer reviewed.

This article is made freely available for use in accordance with BMJ’s website terms and conditions for the duration of the covid-19 pandemic or until otherwise determined by BMJ. You may use, download and print the article for any lawful, commercial purpose (including text and data mining) provided that all copyright notices and trade marks are retained.

© Author(s) (or their employer(s)) 2020. No commercial re-use. See rights and permissions. Published by BMJ.

To cite Mathian A, Amoura Z. Ann Rheum Dis Epub ahead of print: [please include Day Month Year]. doi:10.1136/annrheumdis-2020-218487

Received 24 August 2020
Accepted 25 August 2020

Linked

http://dx.doi.org/10.1136/annrheumdis-2020-218475


ORCID iD
Alexis Mathian http://orcid.org/0000-0002-7653-6528

Correspondence response

BMJ

Ann Rheum Dis Month 2020 Vol 0 No 0
REFERENCES


