Correspondence on ‘Glucocorticoid-induced relapse of COVID-19 in a patient with sarcoidosis’

Patients with interstitial lung disease have been considered at high risk of complications of COVID-19 because of their underlying lung disease and use of immunosuppressive agents.1 However, data on COVID-19 in patients with sarcoidosis are scarce.2-4 Several reasons for an increased risk of severe forms of COVID-19 among sarcoidosis patients have been hypothesised: the involvement of the lung in almost 90% of patients with COVID-19, some of whom have reduced pulmonary function and comorbidities such as diabetes or hypertension, which are largely associated with the use of glucocorticosteroids for treating sarcoidosis; and the use of immunosuppressive agents in a subset of these patients.5 Recently, Gyorfi et al6 described the case of a patient with sarcoidosis who experienced a symptomatic SARS-CoV-2 infection with spontaneous clinical improvement, and a virological relapse after steroids treatment. This case illustrated the fact that immunosuppression with glucocorticoids may induce relapse of COVID-19 in patients with sarcoidosis. However, we lack data on the outcomes of patients with sarcoidosis affected by COVID-19. We retrospectively collected data for all patients with sarcoidosis and SARS-CoV-2 infection seen among 15 French centres between 1 March and 20 May 2020. The inclusion criteria were a sarcoidosis diagnosis based on the American Thoracic Society/European Respiratory Society/World Association for Sarcoidosis and other granulomatous diseases criteria7 and SARS-CoV-2 infection based on at least one of the following: nasopharyngeal or tracheal swab reverse transcription (RT)-PCR positive for SARS-CoV-2; SARS-CoV-2-positive serology; or typical clinical and radiological findings.

Thirty-six patients were included. Among them, 34 patients had a confirmed SARS-CoV-2 infection: 3 were not tested with SARS-CoV-2 RT-PCR but had positive serology; 31 were tested with SARS-CoV-2 RT-PCR, which was positive in 29 patients. The two remaining patients had typical clinical and radiological findings despite negative RT-PCR results and were admitted to the hospital, with one patient being admitted to the intensive care unit (ICU). These two patients were not tested with serology. The demographic data and clinical features of the patients are detailed in table 1. Among the patients, 33% had lung fibrosis. The presenting symptoms of COVID-19 were classical and included fever in most of the patients (67%), despite the use of glucocorticosteroids. Twenty-five (69%) patients were receiving long-term treatment with glucocorticosteroids at the time of COVID-19 diagnosis. The steroids were stopped in only one patient at the time of COVID-19 diagnosis (this patient initially received a daily dose of 7.5 mg). The daily dose of steroids was increased in five patients because of COVID-19 diagnosis. Corticosteroids were introduced in two patients who did not previously receive this treatment for sarcoidosis. In comparison with steroids, methotrexate was more frequently stopped at the time of COVID-19 diagnosis, in 4/8 (50%) patients. Among the six patients under tumour necrosis factor (TNF)-alpha antagonist treatment, the treatment was temporarily suspended in all. All patients were admitted to ICUs when needed.

Five patients died during the SARS-CoV-2 infection: four patients died from acute respiratory failure due to SARS-CoV-2 infection. Of note, two patients had chronic renal failure, one...
was undergoing haemodialysis and the last patient had an acute kidney injury complicating the chronic renal disease and required renal replacement therapy during the COVID-19 course. One patient also had an active thromboembolic disease. The fifth patient, who was receiving a TNF-alpha antagonist treatment for sarcoidosis, died from acute and uncontrollable hypercapnia in the context of chronic obstructive pulmonary disease and obesity. Thirteen patients (36%) were admitted in ICU (Table 1). The admission in ICU was always possible, when decided by the treating physician.

Our findings support previous data obtained on COVID-19 in autoimmune diseases.6–9 Although it is estimated that 15%–20% of people infected with COVID-19 develop severe pneumonia and that 5%–10% require critical care in the general population, we found a higher percentage of patients requiring intensive care support (36%) among the sarcoidosis population, probably because the study population was recruited from hospital-based centres. The percentage of patients with lung fibrosis was similar in patients admitted in ICU and those who were not.

The role of immunosuppressive agents in the course and severity of COVID-19 is still debated.10 Our results share similarities with those of previous studies about COVID-19 in patients with immune-mediated inflammatory diseases.11–13 In a previous study, the use of oral glucocorticosteroids and methotrexate was higher among patients for whom hospitalisation was warranted.11 We found that TNF-alpha antagonist treatment was not associated with more severe forms of the disease, even if this should be considered with caution in this small sample. This is in accordance with the results of previous studies that supported the safety of chronic use of TNF-alpha antagonist treatment.9,11

With this study of 36 patients with sarcoidosis and COVID-19 from a French multicenter registry, we provide a better understanding of the implications of COVID-19 in the sarcoidosis population.
REFERENCES