

## B-cell targeted therapy is associated with severe COVID-19 among patients with inflammatory arthritides: a 1-year multicentre study in 1116 successive patients receiving intravenous biologics

Dear Editor,

A potential association between rituximab and more severe COVID-19 outcomes has been previously raised, based on case reports, retrospective studies and mostly declarative registries.<sup>1-4</sup> To further investigate this association, we focused on patients with inflammatory arthritides (IA) receiving intravenous biological agents at day hospitals to limit selection and recall bias, as well as missing data.

All patients with IA treated in day hospitals with intravenous biological agents (rituximab, abatacept, infliximab or tocilizumab) in seven clinical centres in France (Strasbourg, Colmar, Mulhouse, Nancy, Reims, Clermont-Ferrand and Saint-Antoine

hospitals in Paris) were enrolled in the study. Data were collected from 1 September 2019 (5 months before the outbreak of the epidemic in France, so that all enrolled patients had been exposed to a biologic prior to the start of the epidemic) to 1 January 2021.<sup>3</sup> In each centre, we obtained the list of all patients receiving intravenous biological agents from the hospital pharmacist. Therefore, all patients receiving one of the four drugs within the time frame of the study were enrolled in each centre. The occurrence of hospitalised COVID-19 was the primary outcome criterion, that is, SARS-CoV-2 presence confirmed by PCR and resulting in hospitalisation or death. Data were analysed with Bayesian methods in univariate and multivariate analyses using weakly informative prior (specifying that  $0.05 < OR_x < 20$  a priori) or priors derived from recently published data.<sup>3</sup> A prior distribution is a probability distribution that expresses what is already known on the parameter of interest, such as the OR, through either theoretical consideration and/or past observations, and is a fundamental part of Bayesian methods and inference. Using a prior distribution allows decreasing, at least partially, concerns about the potential lack of statistical power. In order to ensure that any difference in risk with rituximab was not primarily due

**Table 1** Univariate and multivariate models assessing the association between the occurrence of hospitalised COVID-19 and each variable

Variables	Rituximab (n=392)	Other bDMARDs (n=724)	Univariate OR of hospitalised COVID-19 (95% CrI)	Multivariate OR of hospitalised COVID-19 (95% CrI) Model #1	Multivariate OR of hospitalised COVID-19 (95% CrI) Model #2
bDMARDs (RTX vs other bDMARDs)			<b>8.5 (2.4 to 38.6)</b> Pr (OR >1)≈1.0	<b>7.7 (1.7 to 44.7)</b>	<b>4.4 (1.8 to 11.1)</b>
Median age (years)	64 (56–71)	57.3 (47.0–67.0)	<b>1.0 (1.0 to 1.1)</b> Pr (OR >1)≈1.0	1.0 (1.0 to 1.0)	1.0 (1.0 to 1.0)
Female	285 (72.7)	426 (58.8)	0.6 (0.2 to 2.0) Pr (OR >1)=0.2	0.5 (0.1 to 2.1)	0.5 (0.2 to 1.0)
IA diagnosis					
RA	366 (95.6)	305 (42.4)	RA versus SPA 0.3 (0.0 to 1.4) Pr (OR >1)=0.06	RA versus SPA 1.0 (0.1 to 7.4)	RA versus SPA 0.6 (0.1 to 3.7)
Spondyloarthritis (including psoriatic arthritis)	0	364 (50.6)	RA versus other 2.2 (0.4 to 8.7) Pr (OR >1)=0.8	RA versus other 2.3 (0.3 to 13.2)	RA versus other 2.1 (0.3 to 10.7)
Other*	17 (4.4)	51 (7.1)			
Comorbidities†					
Cardiovascular disease	60 (15.4)	167 (23.1)	0.5 (0.1 to 2.1) Pr (OR >1)=0.2	3.6 (0.9 to 16.6)	2.7 (1.3 to 5.8)
Cerebrovascular disease	10 (2.6)	29 (4.0)	0.5 (0.0 to 4.2) Pr (OR >1)=0.3	0.5 (0.0 to 4.0)	0.5 (0.0 to 4.3)
Chronic lung disease	92 (23.5)	84 (11.6)	1.9 (0.5 to 6.4)	1.0 (0.2 to 3.9)	1.8 (0.9 to 3.8)
Diabetes	48 (12.3)	68 (9.4)	2.8 (0.6 to 9.6) Pr (OR >1)=0.8	1.7 (0.4 to 7.4)	2.1 (0.5 to 5.4)
Median BMI (kg/m <sup>2</sup> ) (IQR)	25.8 (23.2–29.4)	27.3 (23.4–31.2)	Normal BMI vs BMI >25 0.2 (0.0 to 1.4) Pr (OR >1)=0.1	Normal BMI vs BMI >25 0.1 (0.0 to 1.0)	Normal BMI vs BMI >25 0.2 (0.0 to 1.1)
BMI >30 kg/m <sup>2</sup>	67 (24.4)	120 (32.3)	Normal BMI vs BMI >30 0.5 (0.1 to 2.6) Pr (OR >1)=0.2	Normal BMI vs BMI >30 0.4 (0.1 to 2.9)	Normal BMI vs BMI >30 0.4 (0.1 to 2.2)
Treatments					
Conventional synthetic DMARDs	242 (61.7)	374 (51.7)	0.6 (0.2 to 1.9) Pr (OR >1)=0.2	0.6 (0.2 to 2.1)	0.5 (0.2 to 1.0)
Other immunosuppressive agents	7 (1.8)	5 (0.7%)	3.0 (1.4 to 6.5) Pr (OR >1) ≈ 1.0	4.0 (0.5 to 30.4)	2.1 (1.0 to 4.4)
Oral glucocorticoids	1 (0–5)	0 (0–0)	No steroids vs 0–10 mg/day 3.0 (0.7 to 11.4) Pr (OR >1)=0.9	No steroids vs 0–10 mg/day 1.7 (0.4 to 7.2)	No steroids vs 0–10 mg/day 1.7 (0.4 to 7.5)
Median dose (mg/day) — (IQR)					
No steroids	190 (48.5)	486 (37.1)	No steroids vs >10 mg/day 2.9 (0.3 to 20.5) Pr (OR >1)=0.8	No steroids vs >10 mg/day 1.3 (0.1 to 10.9)	No steroids vs >10 mg/day 1.5 (0.1 to 11.1)
0–10 mg/day	114 (29.1)	90 (12.4)			
>10 mg/day	13 (3.3)	10 (1.4)			

Model #1: weakly informative prior (specifying that  $0.05 < OR_x < 20$  a priori).

Model #2: taking into account prior according to a recent publication by Strangfeld *et al.*<sup>3</sup>

Bold indicates statistically significant results.

\*Other IA includes vasculitides n=16, juvenile idiopathic arthritis n=12, connective tissue diseases n=11, polymyalgia rheumatica n=10 and others n=19: uveitis, inflammatory bowel disease, stiff-person syndrome, sarcoidosis, inflammatory myositis, calcium pyrophosphate deposition disease, familial Mediterranean fever, Blau syndrome and McCune-Albright syndrome.

†Comorbidities: 'cardiovascular disease' includes abnormal heart rhythms or arrhythmias, aorta disease, coronary artery disease (narrowing of the arteries), heart attack, heart failure, cardiomyopathy, heart valve disease, hypertension, pericardial disease, peripheral vascular disease; 'cerebrovascular disease' includes history of stroke and transient ischaemic attack; 'chronic lung disease' includes asthma, chronic obstructive pulmonary disease, interstitial pneumopathy and pulmonary fibrosis, asbestosis, pneumonitis, obstructive sleep apnea-hypopnea syndrome and history of pulmonary embolism; diabetes includes type I and II diabetes.

bDMARD, biologic disease-modifying anti-rheumatic drug; BMI, Body Mass Index; IA, inflammatory arthritides; RA, rheumatoid arthritis; RTX, rituximab; SPA, spondyloarthritis.

**Table 2** Informative prior used in multivariate analysis Model #2

Variables	Gaussian prior distribution on log(OR), N(mu, sigma <sup>2</sup> )	Prior OR (95% CrI)
RTX versus other bDMARDs	N(1.04, 0.281)	2.8 (1.0 to 8.0)
Median age (years)	N(-0.079, 0.0016)	0.9 (0.85 to 1.0)
Gender	N(-0.757, 0.189)	0.5 (0.2 to 1.1)
Cardiovascular disease	N(0.752, 0.191)	2.1 (0.9 to 5.0)
Chronic lung disease	N(0.752, 0.191)	2.1 (0.9 to 5.0)
Conventional synthetic DMARDs	N(-0.757, 0.191)	0.5 (0.2 to 1.1)
Other immunosuppressive agents	N(0.64, 0.145)	1.9 (0.9 to 4.0)
Other variables	N(0, 0.428)	1.0 (0.05 to 20)

bDMARD, biological disease-modifying antirheumatic drug; CrI, credibility interval; DMARD, disease-modifying antirheumatic drug; RTX, rituximab.






to baseline differences between rituximab and other biological groups, we performed multivariate analyses accounting for risk factors of severe COVID-19 based on literature.

A total of 1116 patients receiving intravenous biological agents were enrolled: 449 with infliximab, 392 with rituximab, 170 with tocilizumab and 105 with abatacept. Ten cases of severe COVID-19 occurred: 9 in patients treated with rituximab (2.3% of total patients treated with rituximab) and 1 in a patient treated with infliximab (0.1% of patients treated with biological agents other than rituximab, 0.2% of patients treated with infliximab) (table 1 and online supplemental table 2). Four deaths occurred during follow-up, but none were related to COVID-19 (a dialysed 50-year-old man treated with tocilizumab for systemic sclerosis who developed a serious non-COVID infection, an 86-year-old woman treated with rituximab for rheumatoid arthritis, who developed a serious pulmonary bacterial infection; and a 62-year-old woman and a 70-year-old man treated with infliximab for psoriatic arthritis, who died of unexplained sudden death). In univariate analysis, the proportion of hospitalised COVID-19 was higher for patients receiving rituximab than other biological agents (9/392 vs 1/724, OR=8.5, 95% credibility interval (CrI) 2.6 to 38.6, Pr (OR >1)≈1; tables 1 and 2). Rituximab remained the only factor associated with risk of hospitalised COVID-19 (OR 7.7, 95% CrI 1.7 to 44.7) in multivariate analyses (table 1). In patients with hospitalised COVID-19 (online supplemental table 1), the median delay from last infusion to infection was 3.5 months (IQR 1.8–5.0). One patient was admitted to intensive care. The sensitivity analysis, in patients with moderate-to-severe and critical COVID-19 (ie, individuals who had SpO<sub>2</sub> <94% on room air at sea level and who required oxygen), yielded the same results as the main analysis in patients with hospitalised COVID-19 (online supplemental table 2).

The present work joins previous studies to confirm the risk of B-cell depletion with regard to the development of hospitalised and severe COVID-19.<sup>1–3</sup> Of note, the low number of events and the number of covariates limit the robustness of the statistical analysis, which might explain that classical risk factors such as age, sex, comorbidities, body mass index and corticosteroids were not associated with severe COVID-19 in the present study. In addition, the present study is the first to provide a prevalence of severe SARS-CoV-2 infection in a cohort which includes the totality of patients receiving intravenous biological treatment. In this study, approximately 2% of rituximab-treated patients developed hospitalised COVID-19, compared with only one

patient (0.1%) among those treated with infliximab, tocilizumab or abatacept.

These results strongly indicate the increased risk of severe COVID-19 in patients receiving B-cell targeted therapy. Among patients with IA, those receiving rituximab should be prioritised for vaccination against SARS-CoV-2, sufficiently in advance of treatment infusion/reinfusion.

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