

COVID-19 guidance in chronic diseases: a need to reach across the borders of the traditional medical specialities

The COVID-19 pandemic poses extraordinary challenges to all physicians, especially managing sick and vulnerable patients, such as those with chronic immune-mediated inflammatory diseases. Inflammatory bowel disease (IBD), rheumatoid arthritis and psoriasis share use of immunomodulators and biologic therapies that pose potential enhanced risks in a pandemic. Despite this considerable overlap, specialist societies have not issued joint guidance, understandable given the short timelines of COVID-19 response. The recently written 'shielding' advice for protecting sick and vulnerable patients released by the British Society of Gastroenterology (BSG),¹ the British Society of Rheumatology (BSR)² and the British Association of Dermatology (BAD)³ had some subtle differences that we want to highlight here as a catalyst for enhancing cross-speciality working.

Both BSR and BAD guidelines include chronic kidney disease (CKD) in their risk stratification guidance for identifying high-risk patients who would benefit from 'shielding' and early identification for self-isolation by the NHS.^{2,3} In contrast, BSG guidelines for such patients with IBD are centred around disease activity and associated respiratory/cardiomatabolic comorbidities without mention of CKD.¹ Current estimates place 20% of the at-risk population (as per Public Health England guidelines⁴) for COVID-19 in the UK, of which around 31.5% are less than 70 years with at least one underlying condition, such as CKD.⁵ Moreover, in a recent UK retrospective study of more than 80 000 persons, IBD was

associated with increased risk of CKD, with hazard ratios highest among younger patients.⁶

It is important to acknowledge that the risk conferred by CKD in the setting of UK COVID-19 infection remains unknown, given the rapidity of the evolving risk factor data.⁷ However, given that mortality in COVID-19 is attributable to cardiometabolic and pulmonary issues and also multiple organ failure,⁸ patients with CKD do likely represent an at-risk population. Indeed, the most recent ISARIC data (predominantly from UK sites) suggest CKD prevalence of more than 9.5% of 1123 suspected or proven COVID cases.⁹

Formulating guidelines at this time is an exceptionally difficult task given the rapidly evolving knowledge base surrounding outcomes in a pandemic and the BSG guidance for high-risk grouping leads the international IBD arena.¹⁰ Nevertheless, we would suggest erring on the side of caution when evaluating risk factors, such as CKD, for incorporation into guidelines. Guidance should then be adapted as new data appear. For the individual patient, other comorbidities (eg, CKD) and clinically relevant events (eg, recent hospitalisation or infection) and not just age must be considered for absolute risk assessment by physicians. As the guidance suggests, in the absence of evidence, it is not possible to specify exact cut-off points for any risk factors; ultimately it is a question of clinical judgement.³

Sharing evidence-based best practice across specialities will help us deliver optimal care for patients and populations not just individual organ-focused outcomes. Rather than divided approaches and siloes, standing together united with fellow colleagues and looking across in bodies such the Royal College of Physicians will provide the best (virtual and actual) base for relief efforts to protect the

public, both in the face of this current crisis and far beyond it.

Tom Thomas,¹ Joht Singh Chandan ,² Ajay Mark Verma ,³ Paul Cockwell,⁴ Emma Vaux,⁵ Neeraj Bhala^{2,4}

¹Translational Gastroenterology Unit, John Radcliffe Hospital and Kennedy Institute, University of Oxford, Oxford, UK

²Institute of Applied Health Research, University of Birmingham, Birmingham, UK

³Department of Digestive Diseases, Kettering General Hospital NHS Foundation Trust, Kettering, UK

⁴Queen Elizabeth Hospital Birmingham, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK

⁵Royal College of Physicians, London, UK

Correspondence to Dr Neeraj Bhala, Queen Elizabeth Hospital Birmingham, Edgbaston, Birmingham, B15 2TT, UK; nijbhala@googlemail.com

Twitter Ajay Mark Verma @AjayMVerma

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ORCID iDs

Joht Singh Chandan <http://orcid.org/0000-0002-9561-5141>

Ajay Mark Verma <http://orcid.org/0000-0002-6432-3357>

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