Clinical guide during the COVID-19 pandemic for the management of patients with musculoskeletal and rheumatic conditions who are:

- already taking corticosteroids, or
- require initiation of oral/IV corticosteroids, or
- require an intra-articular or intra-muscular corticosteroid injection

This updated guidance aims to assist in shared decision making in the use of appropriate corticosteroids (new or ongoing and administered by any route) during the COVID-19 pandemic in patients with musculoskeletal (MSK) and rheumatic conditions. It is published in the context of phase 3 of the response to the COVID-19 pandemic and at the onset of a second wave. It relates to MSK service provision across primary, community and secondary care including rheumatology, orthopaedics and pain services.

It is applicable to adults and children. It reflects the potential problems that may be associated with corticosteroid use in the setting of COVID-19, while recognising the important role that appropriate and considered use of corticosteroids may have to treat patients where there are no alternative treatments.

It is supported by the following professional bodies: British Society for Rheumatology, British Association of Orthopaedics, British Association of Spinal Surgeons, Royal College of General Practitioners, British Society of Skeletal Radiologists, Faculty of Pain Medicine and Chartered Society of Physiotherapy

Intra-articular, peri-articular and soft tissue injections for MSK pain

Indication e.g. to treat osteoarthritis, shoulder pain, lateral hip pain, carpal tunnel syndrome, trigger digit and de Quervain's.

Recommend simple analgesia, activity modification, splinting where appropriate and exercise as first line.

Only consider a steroid injection if a patient has failed first line measures, has high levels of pain and disability, and continuation of symptoms will have a significant negative effect on their health and wellbeing.

Shared decision-making should be employed; the details discussed with the patient to reach a decision to inject should be recorded (such as in the clinical correspondence), and with at least verbal consent obtained.

Consider carefully the dose of steroid to be used, choosing the minimum appropriate dose.

Patients should be given guidance about activity modification and exercise therapy following an injection.

Injections for spinal radiculopathy

All appropriate and available non-invasive treatments should be explored and discussed with patients before injection treatments are considered.

Injections can be offered for severe radiculopathy and as an alternative to surgery. They should be assessed on an individual basis and a collaborative approach taken with other clinicians to guide prioritisation. Patients must be engaged with the process, fully aware of the risks and be able to give informed consent.

In such cases an epidural or targeted nerve root block can be performed with local anaesthetic only or with the lowest possible dose of steroid to be effective.

Patients should be given guidance about activity modification and exercise therapy following an injection.

Intravenous methyl prednisolone

IV methyl prednisolone should be reserved for those with clinically active disease and given on specialist advice only.

Patients in the CEV group and steroids: implications

Adults

- Starting a course of oral prednisolone lasting more than a month may put someone into the CEV group and their name should be added to the shielding list. The implications of this should be discussed with the patient
- Starting oral prednisolone at more than 20mg per day in an adult for more than a month will move a patient into the CEV group
- A one-off steroid injection for local action will not put someone into the CEV group
- A one-off intramuscular steroid injection will not put someone into the CEV group

Children and young people

The Royal College of Paediatrics and Child Health worked with many paediatric and adolescent specialty groups, including rheumatologists, to review the evidence to date.

They agreed that steroids did not put children and young people with rheumatological conditions into the CEV group and therefore they should NOT routinely be added to the shielding list (4).

Should injected corticosteroids still be used during the 9 pandemic?

As per usual practice, individuals with active infections must not be injected with steroids.

A steroid injection is used in MSK services to control inflammatory joint disease, ease pain, increase mobility and improve quality of life. The duration of effect is variable but it can provide benefit for several months and in certain conditions (such as trigger digit) may provide long-term symptom resolution.

In some patients, the use of an injection can avoid the need for surgery or delay it for a substantial period, thereby reducing the risks of patients undergoing procedures at this time.

However, during the COVID-19 pandemic clinicians need to give extra consideration as to whether the benefits outweigh the risks. The incubation period for coronavirus can be long (up to 14 days) with an estimated median time of 5.1 days.

This means that giving a steroid injection to an asymptomatic patient who is carrying the virus could potentially put them at an increased risk of an adverse outcome from the virus, although it is not known that this is the case, and the level of any increased risk has not been quantified to date.

This potential risk therefore needs particular consideration in more clinically vulnerable patient groups, for example patients over the age of 70, adults belonging to BAME groups, those with diabetes mellitus, chronic respiratory disease and high BMI.

Particularly for patients in the CEV group for COVID-19, the benefits of receiving corticosteroids (orally or parenterally) must outweigh the risks for these patients. The potential risks must be explained to patients to allow an informed, shared decision to be reached regarding whether or not to proceed with steroid injection.

This includes attending a setting where higher levels of COVID-19 may be present, although the clinical area will be set up in a COVID-safe way. Provision of prior information to patients may enable these discussions.

To summarise:

An individual risk analysis should take place. Delivery of care should follow relevant national guidance and local delivery plans. If you're a non-prescribing clinician injecting under a patient group directive, you must follow local guidelines.

If you do decide to undertake injection therapy, you must:

1. Adhere strictly to your local infection control policies, including cleaning and use of personal protective equipment (PPE) as required.
2. Adhere to local policies on screening, testing etc. for patients to reduce the risk of COVID infection at the time of the injection.
3. Review if the procedure is still clinically indicated if patient has been on a waiting list for some time.Thepotentialbenefitmustoutweigh the risk.
4. Consider if you can reduce the dose of steroid or choose an alternative medicine to minimise the systemic effects of corticosteroid.
5. Ensure patients are fully aware of the potential increased risk and the lack of clear evidence related to risk during the COVID-19 pandemic. They must be engaged in decision-making.
6. Advise all patients to adhere to regular public health advice, e.g. regarding hand hygiene, social distancing and wearing a mask, to reduce risk of COVID infection.
7. Obtain and document informed consent as per local guidelines prior to proceeding with injection therapy.