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Principles for continued care and support of the clinically extremely vulnerable – dermatology update for clinicians

Executive Summary

1. To date, there is no specific skin disease which appears to alter prognosis in COVID-19 infection. From a dermatology perspective, our published grid, largely based on immunosuppression therapies for all ages, remains unchanged.
2. To date non-white ethnicity, male gender and obesity are emerging risk factors conferring worse prognosis and are expected to be considered in a risk assessment tool commissioned by the CMO, to be published shortly. To be consistent and avoid medical confusion. These risk factors though should not be used to re-profile patient risk in advance of the published screening tool.
3. The dermatology-specific guidance will be regularly reviewed and updated by this group. Key considerations will be given to infection outcomes and vaccine trial data overall, and specifically for infected individuals with skin disease (next review 1st November 2020).

Background

From the 1st August, the government will pause shielding unless the transmission of COVID-19 in the community begins to rise. This document has been developed in response to these proposed changes, to help clinicians treating skin disease guide patient care. During the early phase of the pandemic, medical specialties prescribing significant numbers of immunosuppressive therapies were asked to identify extremely vulnerable individuals considered to be at increased risk of poor disease outcome from COVID-19 infection.

Since COVID-19 is a novel infection, there was a lack of data on immunosuppressive treatment and risk of serious COVID-19 infection. This meant that guidance was opinion- rather than evidence-based. As such, a conservative approach was taken to help clinicians identify extremely vulnerable groups; this was largely guided by the immunosuppressive agents and relevant patient co-morbidities. A dermatology-specific grid was developed and used by clinicians to identify patients who needed shielding.

Overall recommendation:

Currently, this dermatology grid guidance should remain unchanged with respect to specific skin disease and the therapies to treat them. Additional relevant risk factors such as non-white ethnicity, male gender and obesity should be considered by clinicians, in line with the risk assessment tool soon to be published by the CMO.

What will change?

From the 1st August, the government will pause shielding unless the transmission of COVID-19 in the community begins to rise. The support for food parcels, medicine deliveries and care will stop. NHS volunteers will still be able to help with purchased food deliveries, prescriptions, and essential items.

During the first wave of the COVID-19 pandemic, people who were identified as potentially being at higher risk of complications, hospitalisation, or death, if they catch COVID-19, were asked to take extra steps to protect themselves. There are two levels of higher risk: clinically vulnerable (pregnant women, those over 70 years of age, or who have certain long-term conditions) and clinically extremely vulnerable (patients with organ transplants or on specific drugs or treatments).[1]

There is separate national guidance for residents in care homes. It is important to note that advice for clinically extremely vulnerable patients to shield (i.e. to stay at home and avoid face-to-face contact) has always been guidance, not law. The latest guidance indicates that patients who are shielding are no longer advised to do so from the 1st August 2020 in England, and 16th August in Wales.[2]

The updated guidance encourages those shielding to continue working from home if possible, but advises they may go outside to more places and see more people, keeping to social distancing guidelines, and go out to work if their workplace is COVID-19 secure.[3]

What will this mean for our patients?
Due to the change of guidance, many patients are seeking advice from their doctor regarding their risk when shielding is halted and returning to work. Current evidence shows that this risk varies significantly for patients depending on their health condition(s), age, gender, ethnicity, and place of work.[4]

It is difficult for secondary care doctors to identify levels of risk for individuals based on current data available; particularly as prevalence of the virus varies regionally, and workplace and individual risk factors, including co-morbidities, vary from person to person. Therefore, it is not possible for dermatology colleagues to give reliable and detailed advice about shielding, without a reliable COVID-19 risk assessment tool. Below are the suggestions for how we might enter into shared discussion to guide our patients.

Recommendations:

1. Patients need to follow government advice. They should be encouraged to discuss their individual level of risk with their clinician, and be supported to make shared decisions about halting shielding, in line with the most recent published government advice and with appropriate guidance from the occupational health departments linked to their place of work.

[1] https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/
[2] Welsh government https://gov.wales/guidance-on-shielding-and-protecting-people-defined-on-medical-grounds-as-extremely-vulnerable-from-coronavirus-covid-19-html
[3] Public Health England https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
[3] Public Health England https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
[4] Public Health England https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

2. Primary care, secondary care and community services should work together locally to ensure that tests and, where possible, treatments are delivered at home, close to home or within primary care settings for those at higher risk, with opportunities for remote consultations and monitoring, where appropriate, in line with national guidance.
3. Shielding should not be used as a reason to delay or defer urgent and non-urgent healthcare treatment.
4. Work-based risk assessments by occupational and public health teams, **not dermatologists**, should be carried out for those who are shielding prior to returning to work, particularly in high-risk workplace environments such as healthcare settings.
5. NHS England will continue to work closely with specialty societies to support a standardised approach to assessing levels of risk, particularly if infection rates begin to rise once more, either nationally or regionally.
6. Guidance for patients who are clinically extremely vulnerable should be reviewed regularly and updated as appropriate, in line with government guidance and local infection rates. For some patients who are at particularly high risk of infection, more support may be needed.
7. For children or young adults who are no longer advised to shield, there should be a transitional arrangement to support them in this process.

Interpretation of the evidence to date

The global dermatology community set up registries to accrue data about the impact of immunosuppression on the prognosis of COVID-19 in patients with inflammatory skin disease. These can be found on the BAD website and include registries for alopecia and atopic dermatitis, psoriasis, and hidradenitis suppurativa.

To date, no evidence has emerged to suggest that any particular inflammatory skin disease or immunosuppressive therapy confers a worse prognostic outcome in patients with skin disease with a COVID-19 infection. However, the number of people with inflammatory skin disease who are immunosuppressed are, to date, insufficient to suggest changes to the published grid.

The consensus from this group is that ethnicity should also be included as a risk factor within the grid, together with other detailed co-morbidities.[5]

Proposal for future review

Since this is a very dynamic situation with probable vaccine data and a possible second peak of infection in the winter, this group have agreed to review the published data on a regular basis (3-monthly). In the interim, the advice to our patients remains one of caution, with recommendations as outlined above. The coronavirus resource updates, hosted by the Centre of Evidence Based Dermatology in Nottingham, will assist with this.

[5] https://www.nature.com/articles/s41586-020-2521-4_reference.pdf