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Principles for continued care during the second wave of the COVID-19 pandemic to support clinically extremely vulnerable (CEV) patients – dermatology update for clinicians

Executive summary

1. This guidance relates to England. The overarching principles apply across all devolved nations, however, there may be some variation in practice, regulations/restrictions, and guidance.
2. To date, there is no evidence of skin disease altering prognosis to COVID-19 infection.
3. The list of conditions that automatically define individuals deemed as clinically extremely vulnerable (CEV) has been updated by the Chief Medical Officer (CMO) to take into account new evidence, and now includes *adults* with Down's syndrome, on dialysis, or with chronic kidney disease (stage 5). Those on immunosuppression therapies "sufficient to significantly increase risk of infection" remain on this list. These risk factors inform advice given during the current autumn lockdown in England.
4. Clinicians should continue to use the BAD's latest dermatology grid to identify those individuals on immunosuppression deemed CEV (who should be shielding) – this remains largely unchanged. Co-morbid conditions to consider have been updated in light of published evidence. However, CMO guidance also states that "other people can be classed as clinically extremely vulnerable, based on clinical judgement and an assessment of their needs", and therefore, clinicians should continue to exercise judgment on a case-by-case basis.
5. The QCOVID risk-assessment tool QCOVID model, commissioned by the CMO, will soon be piloted in primary care. This tool will be used to identify individuals at increased risk of adverse outcomes to COVID-19 infection. We are aware that the BAD's dermatology grid to identify CEV patients does not fully reflect this and have raised it with the offices of the CMO via the RCP.
6. How the QCOVID tool will guide clinicians and patients regarding absolute and relative risk of adverse COVID-19 outcomes still needs to be determined. We understand that primary and secondary care clinicians will use this tool to support and guide patients and the public; it will take into account relevant co-morbidity, including certain therapies, and it will be refined as further evidence emerges.
7. This dermatology-specific guidance will be reviewed regularly by the BAD's COVID-19 Dermatology Immunosuppression & Shielding Working Group (CoDermIS) in conjunction with the Royal College of Physicians and updated accordingly. Consideration will be given to infection outcomes and vaccine trial data, specifically for infected individuals with skin disease (next review 2nd December 2020).

Background

From the 5th November, in response to increasing rates of infection with COVID-19, the government has advised lockdown in England for a period of 4 weeks, for review on the 2nd December. This

document has been updated in response to these proposed changes, to help guide patient care for clinicians working in both primary and secondary care treating skin disease. 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 grid was developed through consultation and consensus, and used by clinicians to identify patients who needed shielding.

Overall recommendation:
To date, there is no data to suggest that patients treated with immunosuppressive therapies for inflammatory skin disease have a worse prognosis than other patients at a similar age, ethnicity or co-morbidity. However, we continue to accrue data, and therefore, at his stage we suggest that the guidance in the dermatology grid should remain *largely* unchanged with respect to specific skin disease and the therapies to treat them. It should continue to be used to identify patients who are clinically extremely vulnerable (CEV) and need to shield. The grid will be reviewed in the context of the soon-to-be published COVID-19 risk-assessment tool.

Clinically extremely vulnerable patients as applied to dermatology
From the 5th November, in response to rising rates of COVID-19 infection, the government has imposed further restrictions to the population in England with guidance to Trusts and primary care for those patients identified as clinically extremely vulnerable. Until the COVID-19 risk-assessment tool is in regular use, and we have further disease-specific registry and other observational evidence, all dermatology patients will be assessed for their CEV status using the latest dermatology grid.

People in this group should avoid all non-essential travel by private or public transport. This includes not travelling to work, school, shops or pharmacy. They should ask others to collect and deliver, e.g. medicines and shopping, seeking support from friends, family, or a volunteer, including NHS Volunteer Responders.

These new measures will apply nationally for 4 weeks up to 2nd December.

Other people living in a household with someone who is CEV are not advised to follow this guidance.

The workplace
Those identified as CEV are strongly advised to work from home and only travel to work if their workplace is COVID-19 secure.

If they cannot work from home, they are advised not to attend work for this period of restriction (5th November to 2nd December 2020). People in this situation may be eligible for Statutory Sick Pay (SSP),

Employment Support Allowance (ESA) or Universal Credit. Letters are being sent to people who are CEV which may act as evidence in accessing this support.

Social activities

People in this group may wish to meet up with one other person from outside their household or support bubble, e.g. to exercise in an outdoor public place, but it is suggested that they always try to do so as safely as possible by following advice on social distancing.

Children and young people

The evidence to date is that most children originally identified as CEV may no longer need to follow this advice, but that in all instances this requires clarification by their clinician. This is reflected in the guidance published by the Royal College of Paediatrics and Child Health (RCPCH). According to this, CEV children and young people are those with a primary immunodeficiency or those at risk of severe infection due to immunodeficiency induced by their disease or their drugs as part of their therapy (e.g. those on post-transplant immunosuppression). Children and young people with Down's syndrome also appear at a higher risk of adverse COVID-19 outcomes. The RCPCH document defines 'severe asthma' as asthma treated with biological agents or maintenance oral corticosteroids. Therefore, most children and young people on immunosuppressive medication for their skin disease, and who have less than 'severe asthma', are not considered CEV. Our advice for all ages is that, until publication of the COVID risk-assessment tool, children and young people should be identified using the latest dermatology grid.

Recommendations:

1. Patients need to follow government guidance by discussing their individual level of risk with their clinician and be supported to make shared decisions about this risk in line with evidence as it emerges.
2. Primary care, secondary care and community services should work together nationally to interpret the COVID-19 risk-assessment tool when published, with respect to its application in Dermatology patients.
3. Being identified as CEV should not be used as a reason to delay or defer urgent and non-urgent healthcare treatment.
4. For children or young people who are no longer advised to shield, there should be a transitional arrangement to support them in this process.
5. Being identified as CEV confers greater care and restriction, similar to shielding in the previous UK-wide lockdown.

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. Details of these registries can be found on the BAD website and include registries for alopecia and atopic dermatitis, psoriasis, and hidradenitis suppurativa.

No evidence has emerged to suggest that inflammatory skin disease or immunosuppressive therapy confers a worse prognostic outcome in patients with skin disease with a COVID-19 infection. Any evidence so far is insufficient to suggest changes to the latest dermatology grid.

Proposal for future review

Since this is a very dynamic situation with probable vaccine data and new data on risks being collected in ongoing studies, the BAD's CoDermIS Working Group has agreed to review the published and unpublished data, where available, on a continuous basis. 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 and updated weekly, will assist with this.