Q1: Should we be limiting our inpatient/outpatient specialist services? Yes/No

Case scenario: A 34 year old lady with a suspected inflammatory arthritis is advised to consult your rooms/outpatient department.

Your front reception takes the call and advises her that due to the COVID-19 crisis, the doctor is not seeing patients at the rooms.

Q3. Our same patient has clinical features to support active RA, you decided to call patient in for a physical examination which reveals a high swollen/tender joint count, bloods and X-rays are reviewed and you decide the patient requires definitive therapy. After screening and excluding COVID-19, do you?

A] Offer analgesics/anti-inflammatories and defer DMARDs till COVID-19 risk is over.

B] Use injectable steroids (IA/IM) and hold on any DMARDs.

C] Initiate Methotrexate 15 mg weekly and low dose prednisone 7.5mg +/- IAS

D] Opt for CQ and/or SZP as they have a safer profile together with low dose prednisone +/- IAS.

Q4. A 65 year old HT/DM patient with severe PSA has failed MTX therapy and needs to initiate a biologic urgently. She is already high risk for severe COVID-19 infection if contracted? What considerations would you make when selecting an agent?

A] Lowest infection risk, particularly serious infections

B] Drug half-life (shorter immunosuppression periods)

C] Formulation i.e. subcut vs IVI formulation

D] Tocilizumab - it might be protective for COVID-19 related-cytokine release syndrome?

E] All, except D.

Q5. Your patient with well-controlled AS is reluctant to come in for his scheduled biologics infusion due to fear of visiting the hospital during COVID-19? Should you...

A] Postpone infusion till the risk is less. He is doing well and the infusion could be stretched.

B] Switch to a subcutaneous formulation - in same class or alternative class.

C] Reassure patient that your clinic is set up for COVID-19 safety and it is important he continues his treatment.

D] Any of the above is acceptable