

## Complications in Rheumatoid Arthritis due to Corona Virus

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### INTRODUCTION

Musculoskeletal symptoms can develop with coronavirus infection, and leads to other respiratory infections. In general, viral infections can cause arthritis, but the symptoms are broad, ranging from joint pain to pseudo- and chronic arthritis. While chronic arthritis is caused by hepatitis C and some endemic alpha viruses (such as Chikungunya, Ross River, Barmah Forest, Sindbis, O'nyongnyong, and Mayaro virus), self-limiting arthritis occurs with parvovirus B19, rubella or hepatitis B. In contrast, coronavirus usually does not cause clinical arthritis but joint and myalgia. Joint and muscle pain is quite rare (occurs in 1µg). Glucocorticoids do not appear to be beneficial in SARS, but they have the potential to relieve the musculoskeletal manifestations of COVID19. In general, COVID19 seems to patent or be complicated by mild to moderate musculoskeletal symptoms that are indistinguishable from those associated with other respiratory viruses, such as influenza infection. In a large Korean study, they observed that co-infections with endemic human coronavirus, parainfluenza virus, and supervirus increased the probabilities of developing RA. As a result, the COVID19 pandemic could lead to an increase the cases of RA. However, still now there have been no reports of people developing autoimmune arthritis, such as RA, after being infected with SARSCoV2.

The COVID19 disease is having an intense effect on the treatment of rheumatic diseases. On the one hand, a large portion of the predictable operations of rheumatology units have

been impacted by the developing need to care for COVID19 patients; on the other hand, the need to maintain the high level of care required to treat rheumatic diseases. The reduction in the number of physicians currently available in the rheumatology profession, due to illness, isolation, or participation in COVID units, which is difficult to resolve with targeted treatment approaches has now become critical. Heart of the management of all chronic inflammatory diseases. In addition, ensuring proper evaluation of patients taking immunomodulatory drugs and rapid management of disease outbreaks becomes increasingly difficult in this condition. Rheumatologists should advance their work by trying to postpone all non-emergency visits and weighing the potential harm of delaying an in-person visit against the potential harm of infection. Indeed, the COVID19 pandemic has gradually disrupted the traditional model of care, both for rheumatic patients and for rheumatologists, accelerating the transition to distant health care.

Finally, the widespread use of anti-rheumatic drugs in COVID19 patients in pandemic-affected areas (rapidly growing and sometimes irrational market, there is a risk for the delivery of these drugs to patients with rheumatic disease). This challenge has been undertaken in Europe and the United States involving the use of hydroxychloroquine, chloroquine, and tocilizumab. Regulatory agencies and manufacturers should take this into consideration to avoid unintended recurrence of the disease in patients with rheumatic diseases due to treatment disruption.

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