|  |  |  |
| --- | --- | --- |
| Study | Xia *et al*, 2020 | Wu *et al*, 2020 |
| Total patients, n | 30 | 38 |
| Severe-type patients, n (%) | 9 (30%) | 15 (39%) |
| Age, years (mean ± SD/median + IQR) | 54.50 ± 14.17 | 68 (53 to 76) |
| Male, n (%) | 21 (70%) | 25 (66%) |
| Conjunctivitis, n (%) | 1 (3%) | 12 (32%) |
| Positive RT-PCR in tears, n (%) | 1 (3%) | - |
| Positive RT-PCR in conjunctival swabs, n (%) | - | 2 (5%) |
| Positive RT-PCR in sputum, n (%) | 29 (97%) | - |
| Positive RT- PCR in nasopharyngeal swabs, n (%) | - | 28 (74%) |

Table 1 – Data comparison between Xia *et al*, 2020 and Wu *et al*, 2020 studies about ocular findings in COVID-19. Abbreviations; SD – Standard Deviation; IQR – Interquartile range; RT-PCR – reverse‐transcription polymerase chain reaction.

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| --- |
| **Non-infectious uveitis previously on immunomodulatory therapy** |
| **Patients are under higher infectious risk if:** |
| * Under oral prednisolone >20 mg/day (or 0.5 mg / kg / day) for more than 4 weeks,
* Under two or more drugs,
* Immunosuppressants associated with another co-morbidity,
* Under oral prednisolone >5 mg / day associated with another immunomodulatory drug
* Administration of cyclophosphamide or rituximab in the last 6 months.
 |
| **How to manage immunomodulatory therapy** |
| * In patients undergoing dose titration, if possible, interrupt dose reduction and maintain the minimum dose previously effective, ideally until the disappearance of pandemic risk and normalization of evaluation conditions for patients;
* Avoid switching or starting new immunomodulatory treatments until that the pandemic is controlled.
 |
| **Analytical study** |
| * Leukocyte count should stay above 4000/μL;
* Repeat an analytical study to monitor pharmacological toxicity whenever necessary, spacing harvest intervals in patients without evidence of toxicity, with leukocytes> 4000 / μL and without recent increase in dose drugs;
* Prioritize, if possible, harvests in a location close to the patient.
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| **Clinic compatible with COVID-19 infection** |
| * Immunomodulatory therapy can theoretically compromise the response immune system in the early stages of COVID-19. On the other hand, a beneficial effect on the eventual prevention and treatment of “Cytokine storm syndrome” that characterizes stage III of COVID-19 (with emphasis on interferon and tocilizumab) could be seen.
* Asymptomatic patients suspected of having a COVID-19 infection:
* Blood count should be monitored;

 - To discuss with the doctor responsible for monitoring of SARS-CoV-2 infection the need to reduce or suspension of immunomodulatory therapy;- Testing will be desirable screening for SARS-CoV-2 infection;* Symptomatic patients with confirmed COVID-19 infection:

- Temporary interruption of immunomodulatory treatment, (conventional or biological) until complete recovery of COVID-19 infection;- In systemic corticotherapy, the minimum time required for tapering should be guaranteed; - The maintenance option of interferon or tocilizumab should be mandatorily discussed with the doctor responsible for the treatment of COVID-19 infection.  |

Table 2 : Recommendations for evaluation and therapy management in non-infectious uveitis on immunomodulatory therapy during COVID-19 pandemics based on Portuguese Group of Ocular Inflammation.