



COVID-19: One Year Later

Hosts: Rebecca Gillett, MS OTR/L, and Julie Eller

Guest: Ted R. Mikuls, MD, MSPH

It's been one year since the COVID-19 pandemic has changed our lives. And while we're all more familiar with practical ways to help keep us safe – social distancing, good hand hygiene and mask wearing –many people with arthritis are still left wondering how this virus will affect them.

In this episode, our guest expert will discuss what has been learned about the impacts of COVID-19 on the arthritis community, as well as help answer questions about vaccines, emerging virus variants, medications, disease flares and more.

Ted Mikuls, MD, MSPH, is a professor of rheumatology and vice chair for research, internal medicine and the division of rheumatology at the University of Nebraska Medical Center. He is the chair of the American College of Rheumatology COVID-19 clinical task force, which focuses on adult patients with rheumatic disease. He currently serves on ACR's COVID-19 vaccine task force.

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COVID- 19: One Year Later
Tuesday, February 16, 2021

Transcript:

PODCAST OPEN

Welcome to Live Yes! With Arthritis, from the Arthritis Foundation. You may have arthritis, but it *doesn't* have you. Here, you'll learn things that can help you improve your life and turn No into Yes. This podcast is for the growing community of people like you who really care about conquering arthritis once and for all. Our hosts are arthritis patients Rebecca and Julie, and they are asking the questions you want answers to. Listen in.

Rebecca Gillett:

Welcome to the Live Yes! With Arthritis podcast. I'm Rebecca, an occupational therapist living with rheumatoid arthritis and osteoarthritis.

Julie Eller:

And I'm Julie, a JA patient who's passionate about making sure all patients have a voice.

MUSIC BRIDGE

Rebecca:

Thanks for joining us on this episode of the Live Yes With Arthritis Podcast. Today, Julie, we are talking about COVID-19 a year later.

Julie:

I feel like we've been talking about COVID-19 for a whole year, actually. (laughter) Every episode has some kind of COVID-19.



Rebecca:

Yeah. It's been quite a journey. 2020 is a year to forget. But we won't be able to. We've learned so much along the way. And it really is hard to believe that it's been about a year that...

Julie:

It's been about a year...

Rebecca:

... we did that first COVID-19 and arthritis episode, trying to ask so many questions. So today, I'm really excited about trying to get an update on where are we with COVID-19.

Julie:

And it's hard to think about how much has changed, how many lives we've lost, how much our job, our workforce, our life, our home life, the communities we see, the communities we serve — how all of that has shifted this year. Just getting ready for this episode, it's been a big time of reflection for me. I'm sure it has been for you also.

Rebecca:

It's hard to believe we've been pretty much doing everything from home. And hard to believe there's a lot of friends and family we haven't been able to see or gather with. But there is some light at the end of the tunnel to me, I think, knowing the vaccine could be on the horizon. Just waiting for that time. And, of course, anxious about whether or not I should take the vaccine. And I know so many people have questions out there. So, I am excited about our guest today.

Julie:

Me, too. He can answer all of our questions about the vaccine. All of our questions about how does COVID-19 get transmitted from person to person, from patient to patient, from arthritis patient to arthritis patient. And so on.



So, we are so excited to have our guest today, Dr. Ted Mikuls, who is the professor of rheumatology and the vice chair for research, internal medicine and the division of rheumatology at the University of Nebraska Medical Center. He is the chair of the American College of Rheumatology COVID-19 clinical task force, which focuses on adult patients with rheumatic disease. And he led our efforts to produce treatment guidance that was announced in April. He currently serves on ACR's COVID-19 vaccine task force. So, we could not have a better guest to talk about arthritis and COVID-19 with us here today.

Dr. Mikuls, thanks so much for joining us.

Dr. Ted Mikuls:

You bet. It's good to be here.

Rebecca:

When we first did our podcast a year ago in March, there were so many questions and hardly any answers. So much has changed. Is there light at the end of the tunnel?

Dr. Mikuls:

It has been a long year, hasn't it? I do think we are seeing light at the end of the tunnel. I'm just not sure how long the tunnel is.

It's been amazing to see what's been accomplished in such a short period of time. And I would also say that we have learned a lot by taking care of patients and talking with patients over the last nine to 10 months. But unfortunately, there are many, many questions we all still have. And I think there's a lot still to be learned.

Julie:

I think that's so right. And there's something I think kind of special about this year in that, for the average American household, public health has become a really familiar term. And the research process has become a little bit more familiar. But even with all of that familiarity by necessity this year,



there's still a lot of unknowns and so many questions that we have. When it comes to this new strain of a virus that is more contagious, it feels scary to be at this point and to see this thing coming and hitting our communities. What do we have to do that's different than what we started doing last March?

Dr. Mikuls:

I think we need to hold fast to the things that we've been talking about for now several months. And that's, you know, I think by now... For much of society it has become almost second nature: social distancing, masking, hand hygiene and now, thankfully, vaccinating, when vaccination becomes available.

I am not a virologist. I'm not a microbiologist. But my understanding of the new strains is that, thus far, the feeling is that our vaccination will help with those strains. And the quicker we can get, the term that's been thrown out there so often is herd immunity, the sooner we can get there, the better off we're all gonna be.

Julie:

Yeah. We know so much more now than we did a year ago. We know how to wear a mask to the grocery store. And we know how to have six feet of distance between the person walking down the hall and yourself. And we know how to have better hand hygiene. So, whenever I think about the scary things that are coming, I also take comfort in the things that we really know and are second nature now.

Dr. Mikuls:

Absolutely. One of the things I tell patients is: We've seen very little spread of this virus in health care settings. Why is that? It's because, in the health care environment, providers and patients are being so careful. And I think it's hard to argue against that. We're seeing huge drops in seasonal influenza. Like enormous drops.



Rebecca:

I think one of the things, like Julie said, we take comfort in knowing what to do to protect ourselves. But there's still this question that is sitting out there. Are those of us who are autoimmune patients more susceptible to this virus because we're on disease modifying drugs or medications that weaken our immune system? Do we know an answer to that yet?

Dr. Mikuls:

We grappled with that question. We still grapple with that question, you know, from March on. I don't think there's compelling data that my patients — my patients with rheumatoid arthritis, my patients with lupus and particularly patients who are well controlled with those conditions — are at increased risk for infection. And I'm certainly not aware of compelling data that would suggest that those patients do worse when they do get infected. So, I think the data I've seen is limited, but it has offered reassurance. That's one of the things I try to share with my patients 'cause this has been really anxiety provoking for rheumatic disease patients.

Rebecca:

You can say that again. (laughs)

Julie:

That's right. And I think that when it comes to the anxiety factor, a lot of it is, what do we know? What don't we know? What can we do? But I have seen from our community a remarkable sense of, "Hey, we've done this before. We've been immunocompromised for a long time." (laughs) "We've got some tips and tricks for folks who are just experiencing this kind of fear of disease transmission for the first time."

When it comes to the anti-inflammatory medications that autoimmune patients or arthritis patients are on right now, there's been a lot of talk about whether these are good for combating COVID-19. Can you talk a little bit about whether they're protective or not protective? What do you think?



Dr. Mikuls:

We have to think about COVID-19 in different phases. There is the infection itself. So, could a medicine make you more apt to get the infection? I think that's one area we have to think about. But then, could there be a separate effect on what your body does with the infection? A lot of the bad outcomes of COVID relate to this inflammatory response that our bodies have to the virus. And for those on anti-inflammatories, one could hypothesize that maybe those patients might be protected by anti-inflammatories from the serious outcomes that are related to inflammation from the virus.

I think there's some evidence to suggest that that part is actually true. So, from the very beginning, people battling this virus have been repurposing many of the medicines that we use. So, rheumatologists have become really popular.

Rebecca:

Yes. You did. (laughs) All the medications that we take... people are actually hearing the names of them, right?

Julie:

Yeah.

Dr. Mikuls:

I think the ones we have probably the best data for, in terms of people with severe sequelae of COVID, have been steroid medicines. And the one that gets used in hospitals quite a bit is a medicine called Dexamethasone, which is a steroid.

A medicine that's called Baricitinib, which is a kinase inhibitor approved for the treatment of rheumatoid arthritis, is actually now being repurposed with good data in the treatment of inflammation related to COVID-19 and pneumonia related to COVID-19. That's interesting. And again I think provides some rationale for reassurance that we give our patients.



Julie:

That's certainly a reassuring thing. When it comes to repurposing a medication that's meant for arthritis for another indication, do you see that that causes supply chain issues? I think everybody became so familiar with the fear of hydroxychloroquine not being available at the very beginning of this thing. Are we still seeing that kind of issue?

Dr. Mikuls:

Yes, there was absolutely a concern early on, you know, with news reports and lay reports of potential efficacy and wide use of hydroxychloroquine. But I think as the data has come out and shown that that is not an effective prevention or treatment for COVID-19, that those supply chain issues have really diminished.

PROMO:

Your input makes a world of difference in getting more arthritis research funding and changing policies that help those in the arthritis community. Make change happen by participating in the Live Yes! INSIGHTS survey for adults and for JA parents. Go to <https://www.arthritis.org/liveyes/insights> to get started.

Rebecca:

We talked about, you know, the role of anti-inflammatory medications being protective. There's also been a demand for supplements. So, do supplements like Vitamin D and C and zinc play any role in strengthening our immunity and lowering our infection risk when it comes to COVID?

Dr. Mikuls:

Oh boy. (laughter) You can tell by my sigh and my pause that I don't have a great answer there. Compelling evidence for the use of those supplements, while that's always attractive, because supplements are reasonably inexpensive and they're very accessible, there's not great data, really robust data, to support the role for those in preventing or treating COVID.



For a patient who's Vitamin D insufficient, who has low Vitamin D levels, I mean, being on Vitamin D supplementation makes sense. But beyond that, whether it plays an anti-viral role, I think that's questionable.

Rebecca:

Here's a question actually Julie and I were grappling with, and it's hard to believe it was a year ago: When you are on these immune-suppressing drugs, can you take these immune-boosting supplements, like Airborne and all these things out there that can boost your immune system? Doesn't that counteract the medication you're on?

Dr. Mikuls:

Again, I'm not an expert in all these supplements, so I just wanna (laughs) put that out there...

Rebecca:

No, that's fine.

Dr. Mikuls:

This is a conversation I've had with patients for years. And it seems like the supplement changes periodically. So, several years ago it was echinacea. And recently, turmeric has been a very popular supplement. There are nuances to all of these.

I always tell patients just because something is natural doesn't necessarily make it safe. So, you know, arsenic... (laughter) I don't think of as being very safe. Most of these things are generally pretty well tolerated. And even my patients with active autoimmunity, many of these supplements they tolerate quite well. But you do have to be careful. Because every patient's different. And they cost money.

Julie:

There's so much that we have to be really cognizant of, especially as it relates to cost and arthritis and COVID. How do you protect yourself? What can you do? And I think one thing that people are



curious about is the vaccine. What is that gonna look like? Is it gonna be very expensive? Out of reach? How do I get it? When will I get it?

Dr. Mikuls:

There's currently two vaccines that have been given emergency use authorization by the FDA here in the United States. One by Pfizer and one by Moderna. And both of those are an mRNA vaccine, which is really a new technology. It's really kind of amazing to think about. And the cost, you know, despite the money that's gone into developing these and the rapidity with which they've come out, I don't think these are gonna be cost prohibitive for people to get.

I think the important part of your question was, you know, what about my arthritis patients? There's been tens of thousands of patients studied on these vaccines. But, unfortunately, very few rheumatology patients. So, while I feel pretty good about these vaccines, I think there is an unknown. I think and I hope that these are gonna be safe vaccines for the vast majority of my patients.

Rebecca:

Although we don't know specific to our community, can you explain what the mRNA vaccine means? It's a new type of biotechnology and it's hard, I think, for people to understand.

Dr. Mikuls:

The mRNA vaccine is actually not necessarily a new technology or new thought. It's actually been something that people have been thinking about in terms of a vaccine strategy for years. And COVID-19, unfortunately for the world, has provided a need for rapid development of a vaccine.

mRNA stands for message RNA, or ribonuclear acid. And that is basically... DNA gets incorporated into cells, and our cells then incorporate that and manufacture COVID-related protein for a limited period of time. Then that protein that is made by our cells acts as a new protein that our body hasn't seen. And our body responds to that by forming antibodies and cell responses that attack that protein. I mean, that's pretty amazing to think about.



That's been developed and tested in a period of nine months. It's absolutely astounding. I think one of the big questions when you hear that, that sounds like almost gene therapy or DNA therapy. And it is not. It actually does not equate to that. And it's not a live virus vaccine. So, the risk of getting COVID-19 from the vaccine is essentially zero. It IS zero.

Rebecca:

What are the side effects that you might expect if you do get the vaccine?

Dr. Mikuls:

I got my first COVID vaccine a couple weeks ago. And, you know, my arm was sore...

Julie:

Congrats! That's awesome!

Dr. Mikuls:

And I think I had a similar experience to a lot of my colleagues. I tolerated it very well. But my arm was a little bit sore for a couple days. And there are patients ... and certainly after a shingles vaccine, I've seen this in clinic, patients who will get, almost like they have flu-like symptoms ... myalgias and such. And the concept there is that, you know, through a vaccine, we are turning on your immune system. Sometimes these symptoms tell us: Guess what, you got the vaccine ... it's working.

Julie:

You did it. You got the real thing. (laughs)

Dr. Mikuls:

So, the things I have heard from patients are muscle aches, certainly local irritation, headaches. Some patients develop low grade fevers after the vaccine. Usually very self-limited though, within the first day to two days.



I think there have been about 30 cases of severe allergy of the millions of doses that have been given thus far. It's not common, but patients can have an allergic reaction. It's not entirely clear what's driving that allergic reaction.

Julie:

OK, that's helpful. And correct me if I'm wrong, but many of these side effects tend to come after that second dose. Is that right?

Dr. Mikuls:

I'll tell you in a couple weeks. (laughter) That's a good point. I have heard the same. That it's a little more common after the second dose. And that kind of makes sense, doesn't it? Because if you think about, you've really turned on that immune system, trained it to recognize this protein.

They can have... I wouldn't call it serious or severe side effects, but more clinically relevant side effects. More aches. Might even knock them out of work for a day or two. I mean that could happen, so...

Rebecca:

That begs the question of what about potential drug interactions with disease modifying drugs that we're currently on? Do I need to hold off my medication before I get the vaccine? Or after?

Dr. Mikuls:

We know with existing medicines, some of which are used for RA, for example, and other rheumatic conditions, that these medicines are associated with a blunted immune response after vaccines. Usually though, the reassuring thing I tell patients is that even though it might reduce that response often, patients still get a protective response. Even though it's reduced, it's still protective.



So, my feeling from that and the guidance I've given thus far has been, even if you're on these medicines, I think you should get the vaccine. Now do you hold the medicine or stop? Let's say you were taking a shot medicine that you did once a week or every two weeks. Well, it's a little complicated, because we have two shots we have to give you three weeks apart. Now think about that. How are we gonna do that? And so, while I would be game to hold a medicine for a short period of time in a patient, I get less enthusiastic about it when we start talking about holding medicine for several doses around a vaccine.

So, that was a lot of words to say I don't know. (laughter) For most drugs, not all of them, but for most drugs like methotrexate or maybe the anti-TNF biologic, I would probably not hold those. I'll probably have patients get their vaccine and stay on their medicine. For drugs like Plaquenil or hydroxychloroquine, same thing. For low-dose steroids. I think it gets a little trickier with a few of the biologics on exactly what to do.

Rebecca:

I'm one who gets infusions every four weeks. For somebody who's on something like rotexion, somebody who's on one that they get every six months or something like that. What's the best way to time it? Right after I get the infusion? Or when I'm almost due for the infusion? Or right in the middle? Do I get both doses in between? There's no guidance on that yet. Right?

Dr. Mikuls:

No, there really isn't. I'm just gonna pick on a class of medicines. One of the most common groups of biologic medicines are these anti-TNF medicines. And some of the trade names that people are familiar with are Enbrel and Humira and ... And with influenza vaccination, you know, the studies they've done, at least antibody responses to the vaccine, don't seem to be reduced much when you're on those drugs. We would hope that that's what we see with the COVID vaccine. We don't know though.

What I don't want to happen is I don't want to hold medicines and have my patients flare and have the underlying rheumatic disease become the major issue. You know?

Julie:

Right.



Dr. Mikuls:

And then so ... And I can see that happening if patients start to hold medicines for prolonged periods. We could run into some problems.

Julie:

That's a really good point. And I think it's consistent with what we've heard before. Continue taking your medications. You wanna keep your arthritis under control. Having controlled disease is going to help better protect you from getting COVID-19 and so on and so on. Talk to your doctor.

Dr. Mikuls:

Absolutely.

PROMO:

The Arthritis Foundation is working with researchers at Johns Hopkins University to recruit patients for **an important study. It's about the impact of COVID-19 vaccines on people with immune compromising conditions like rheumatoid arthritis. Learn more and see if you're eligible to participate at vaccinresponse.org.**

Julie:

How do we know we're getting the best information from our provider?

Dr. Mikuls:

There is an ongoing effort quickly moving along to provide guidance to our patients and the providers on how to optimize vaccinations in our patients. You know, patients with arthritis and lupus and connective tissue disease. And based on the medications they're receiving. How can we optimize that?



Unfortunately, I think vaccinating 300 million people plus in the United States is gonna take a while. It's incumbent on us to get the data that we can in a short period of time to inform our decisions. It's a big job. It's not gonna be easy. But we need to do it.

Rebecca:

Yeah. So many questions you're gonna get and not a lot of answers that are gonna be maybe reassuring. But is there some advice that you would give to one of your patients who's concerned about the vaccine and wants to wait and see before getting it?

Dr. Mikuls:

I personally kind of try to touch on: What are your concerns and where are the anxieties over this coming from? And we try to take those on. One of the concerns I've heard has been: I could get COVID from this vaccine. That risk really is nonexistent. And so, if that's a concern, I really try to talk them through that. But I also don't shy away from saying there are unknowns. We wanna get to the other side. I think the vaccine is a strategy that's gonna help us get there sooner.

Rebecca:

If a patient has had COVID, should he or she still get the vaccine?

Dr. Mikuls:

My understanding, from what the CDC and others who are a lot smarter than I am about this are saying, is that people should get vaccinated who have had COVID. There is some concern about people getting vaccinated very early after infection with them having this kind of overly robust immune response to the vaccine. I think the recommendation from the CDC has been a 90-day wait after infection to get that first dose. This is always a moving target. You can hear my hesitation because there may be new guidance out that I haven't seen in the last few days.



Julie:

But you do think then that even if you've had it, that it's worth having the vaccine and becoming vaccinated? You're not inoculated forever if you've had COVID-19. You're not safe from getting it again.

Dr. Mikuls:

Well, we really don't know. There have been reports of people getting, you know, multiple infections. The analogy I can give to patients, 'cause maybe they've thought more about this, is shingles. So, people get shingles and they come in and say, "Should I get the shingles vaccine?" And the typical guidance has been yes, you should.

And even though the infection, in some ways, acts as a natural vaccination, I think the belief is, because patients are at risk for continued problems from viral infection, that they should be protected with the vaccine.

Julie:

It's a great answer. And it begs one more question. Do we anticipate that the COVID-19 vaccine will be similar to the flu vaccine? That you have to get it year over year? Is it something we just don't know yet?

Dr. Mikuls:

Well, somebody smart probably knows... (laughter) I don't think we really know exactly. I think this could become a vaccine that we talk about boosting down the road. If this becomes a seasonal issue, gosh forbid, that we do talk about recurrent immunization...

Rebecca:

Yes. We're a living human science experiment. It's ongoing. The ACR did release some interim guidance last year about medications that we are on and the safety of staying on them or not. Has there been any potential changes on this information based on changes with the virus or vaccine?



Dr. Mikuls:

Are you talking about the COVID-19 clinical guidance?

Rebecca:

Yes.

Dr. Mikuls:

So, that was first released in April of 2020. It's undergone a couple different renditions or editions since that initial release. Just touching on those, the additions that came out were... One dealt with when can patients safely restart medicines following COVID-19. And there's now guidance on that.

We also released additional guidance specific to the use of Plaquenil, which we talked about a little while ago. Hydroxychloroquine is the generic name of that. But the core of the guidance really hasn't changed.

For patients who are doing well, who haven't had an exposure, who aren't infected with COVID, they should stay on their medicines. They should control their disease. The basic tenets of that guidance I think are still intact.

Julie:

What words of wisdom or comfort do you have for patients who are just trying to keep their arms around the information that's just so rapidly changing around them?

Dr. Mikuls:

The control that we all have over our environment and how we can protect ourselves and our loved ones, we need to hold to that. While this mass vaccination effort continues, we are in control, largely for controlling risk and protecting others. And we need to continue doing that.



And the reassurance is that the vast majority of my clinic population, my colleagues' clinic populations, are doing just great. They have lots of anxiety, lots of concerns, but they're making it.

We have to be vigilant about asking questions and going after answers. Because there's still a lot of unknowns as have kind of percolated through this conversation. But we shouldn't be satisfied with that. Our patients shouldn't be satisfied with that.

Julie:

Sometimes you just need to hear it from a trusted voice. There are only so many things that you can really wrap your arms around. And seeking control over a body that doesn't always feel like yours to control is a really important thing. But especially empowering us to think about how we interact with our communities right now. I really love that. Thank you, Dr. Mikuls.

Dr. Ted:

You bet.

Rebecca:

Is there any difference that we know of between, like, rheumatoid arthritis patients, psoriatic arthritis patients and maybe patients with ankylosing or axial spinal arthritis, if they've gotten COVID, that you've seen?

Dr. Mikuls:

We don't know enough. I mean, that's kind of the bottom line. And there's been lots of reports, and I think you'll both be shocked to know they don't always agree. (laughter)

It appears that your risk for doing poorly from COVID relates not as much to the rheumatic disease that you happen to have or the medicine you happen to take for that rheumatic disease. But other illnesses that may live with your rheumatic disease.



Patients who have heart disease, who have high blood pressure, who have diabetes, seem to do worse with COVID-19. And unfortunately for us, for rheumatologists and our patients, those conditions do coincide with rheumatic disease often. Those are the things that really heighten my awareness, you know, in terms of patient risk. More so than rheumatic disease.

One of the distressing factors we've seen: In minority populations, there are worse outcomes. That's a population we really have to think about.

Rebecca:

You talked about heart conditions and high blood pressure. But a lot of people sometimes with rheumatic disease will also have a pre-existing lung issue. So, that is another category...

Dr. Mikuls:

Chronic lung conditions are concerning. And that kind of makes sense, doesn't it, since COVID can cause pneumonia if you have a low lung reserve from an underlying lung condition.

Julie:

I guess one other question is related to: When someone with arthritis also has COVID-19, how do they tend to fare? Do they tend to be hospitalized?

Dr. Mikuls:

The reassurance I offer patients, and that mainly has come from these case series or case reports that have now been published by several groups, suggesting that rates of infection... So, rates of a positive COVID-19 test, rates of ending up in the hospital, or rates of severe COVID, ending up in an ICU for instance, or having pneumonia, or requiring mechanical intubation, don't seem to be necessarily, at least consistently, in these studies, increased in rheumatic disease patients. My rheumatic disease patients, based on the reports that are available, seem to fare about like everybody else.



But people are so different. How they respond to COVID is just so unique and different and heterogeneous among patients. And so, I've seen patients who have every co-morbidity that you'd worry about getting COVID. And they're like, it was nothing. And I've seen patients with no co-morbidities with severe COVID. It is amazing how different people respond to this.

Julie:

Yeah. I think that at the end of the day, when we take a look at all things COVID 10 years from now, when we're looking back on this, we'll be able to really see the stories that the data tells. And how much we did not know at this moment one year in. How much we're going to learn over a long time.

Rebecca:

COVID-19 and the pandemic really has changed how we've accessed care and being able to communicate with our rheumatologists. Do you think tele-rheumatology is gonna be the new norm for us?

Dr. Mikuls:

It's really changed. It was amazing to be part of that, to watch telehealth literally roll out in a matter of days at most of our centers. I'm probably where most rheumatologists and providers are in that it has been wonderful for many of my at-risk patients, patients who are really anxious about, especially early on in the pandemic, coming to a health care facility.

I think that it's an amazing technology that for a lot of visits really is fantastic. You know, for that stable patient who has to travel five hours, and really what we want is a laboratory surveillance checkup and wanna see how they're doing and check in. I think that's a wonderful use of that technology. For a patient who has symptoms, who I can't feel their joints, that's a problem. I think telehealth, tele-rheumatology, is here to stay. It's not going away. And I think we just all have to work to figure out how we can best fit it into our practice and make it work for our patients.



Julie:

It can really be a partnership in figuring out what are the things we want to keep around. What are the things that need to change for the better? And how can we do this together, provider and patient, hand in hand? So, I feel very excited about the innovations to come in tele-rheumatology.

Rebecca:

Yeah. With the shortage of rheumatologists that exists in our country, I think access to a rheumatologist using this platform can break down some of those barriers, especially for rural areas. The vaccines, I know, are not approved for younger kids. What are the options for families who have kids with juvenile arthritis?

Dr. Mikuls:

I'm not a pediatric rheumatologist. I'm not a pediatrician or an immunologist. I can speak from common sense. What can families do? Well, you know, the adults in the family, when they can, should get vaccinated, social distancing, masking. This is going to be a family affair for sure. Household affair. There's no getting around it.

PROMO:

Learn the latest about how COVID-19 may impact people with arthritis. And get the support you need during the pandemic, including information about the vaccines. Visit our Care and Connect Center at <https://www.arthritis.org/care-connect>.

Julie:

Dr. Mikuls, thank you so much for walking us through so many of our questions. If you had to send our listeners off with your top three takeaways for them to carry with them after this episode, what would you want those to be?

Dr. Mikuls:

I think number one would be reassurance. We're gonna get to the other side of this. The light is at the end of the tunnel. We've got a long tunnel to traverse. But we're gonna get there.



Number two would be we control our risk. Know we are in control of that. And we need to remember that as we traverse this long tunnel.

I think the last thing I'd leave patients with is communication. The rheumatologists I know value patient input into care. What do I do with my medicines? Do I take this vaccine? That's a conversation. And we're ready for that.

Rebecca:

Thank you so much for joining us and giving us a good check-in of where we are a year later. And reassuring us that we can still continue to do the right things to keep ourselves safe and for giving us some more information about the vaccine. So, thank you so much for your time, Dr. Mikuls.

Julie:

Thank you.

Dr. Mikuls:

You bet. It was great to be here.

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This Live Yes! With Arthritis podcast was brought to you by the trusted experts of the Arthritis Foundation. We're bringing together leaders in the arthritis community to help you make a difference in your own life in ways that make sense. You may have arthritis, but it doesn't have you. The content in this episode was developed independently by the Arthritis Foundation. Go to <https://www.arthritis.org/liveyes/podcast> for episodes and show notes. And stay in touch!