PATIENTS WITH ASPLENDIA OR SPLENIC DYSFUNCTION –GUIDANCE DURING COVID-19

Should patients with asplenia or splenic dysfunction be considered at high risk of developing Covid-19 related complications and therefore be placed on the Shielded Patient List (SPL)?

The Government is reviewing the shielding policy as it learns more about COVID19 and the risk factors involved to ensure patients are given the most helpful advice for their condition. In England, until this review is concluded, no further clinical guidance will be issued, and the criteria will remain unchanged. Please see the latest advice on the NHS digital website:

- Splenectomy- further information
- The Coronavirus (COVID-19): Shielded patients list

Recent guidance from the British Society for Haematology (BSH) has clarified that:

- There is no evidence that the lack of a spleen, or part of a spleen, or a non-functioning spleen on its own renders patients at higher risk of Covid-19
- Recommendations for shielding therefore depend on the underlying cause for splenectomy or asplenia and any associated co-morbidities and treatments.
- Splenectomy for trauma and splenectomy for autoimmune disorders, but not currently taking immunosuppressive treatment and not on the SPL due to underlying disease, do NOT need shielding

What are the four main recommendations to all patients from the BSH guidance?

- Patients should ensure they are up to date with their vaccinations
- Patients taking regular prophylactic antibiotics should be encouraged to continue
- Those who are not taking antibiotics should have a supply at home to take if unwell and instructed to do so by a clinician
- All patients reporting a new fever should be evaluated for bacterial as well as viral infection

What does this mean for patients with asplenia or splenic dysfunction that have been identified (either by the practice or the Medicines Optimisation Team Splenectomy Audit) as not having all the required vaccinations?

- Local guidance is that vaccinations for shielded patients can be delayed due to the risk of increased exposure to the pathogen if bringing them out of shielding, as shielding should reduce their risk of acquisition of new bacterial and other viral infections.
- The exception to this is if a patient has not had PPV23. This is due to the risks associated with secondary bacterial infection if the patient acquires Covid-19:
  - Public Health England (PHE) has recently advised with regards to the shortage of PPV23 vaccine and has stated that patients with asplenia or splenic dysfunction who have never had a PPV23 vaccination should be offered the vaccine as high priority. Those who require the 5 year booster are considered low priority
  - Therefore patients who have not had the first dose of PPV23 should be invited to practice to have the vaccination as long as systems and processes are in place to maintain strict social distancing
  - For patients who have not had the PPV23 booster, following discussion with the local haematology team, there are certain patients who they recommend should be called into practice. These are:
    - Those with a history of previous invasive pneumococcal infection. These patients should receive a booster even if they remain on prophylactic penicillin
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- Those who DO NOT take prophylactic penicillin AND are overdue their PPV23 booster
- We encourage practices to complete all outstanding vaccinations as soon as practically possible once lockdown measures have eased.

What about patients not prescribed or not taking their antibiotic prophylaxis?

- The Medicines Optimisation Team Splenectomy audit will have highlighted patients who are not prescribed or are non-concordant with antibiotic prophylactic therapy. Patients who are non-concordant should be contacted to explain the importance of taking the antibiotic regularly as prescribed.
- If unlikely to comply or not prescribed antibiotic prophylaxis, a seven day emergency supply of amoxicillin 500mg tds (or clarithromycin 500mg bd if penicillin allergic) can be given to the patient, to be available for them to take at the first signs of any infection.

What about Sickle Cell Disease (SCD) and Thalassaemia?

- Patients with SCD (which is associated with hyposplenism) are currently considered clinically extremely vulnerable and need to be shielded.
- Patients with thalassaemia or rare congenital anaemias who are at particularly high risk from Covid-19 will include those who have significant iron overload (Cardiac T2*MRI value <15 mg/g or ferritin >3000 mg/L) OR those with a splenectomy in combination with another risk factor for complications e.g. diabetes. GPs may not have access to this information and should contact the patient’s Secondary Care Consultant if there are any queries.
- More information on patients with SCD and thalassaemia was published by the British Society for Haematology on 28th August 2020: Advice to clinicians on risk assessment for severe COVID-19 in patients with haemoglobinopathies and inherited rare anaemias
- Please note that the Medicines Optimisation Team Splenectomy audit did not include patients with SCD and thalassaemias.

Key Points

- The underlying cause of the asplenia or splenic dysfunction determines whether a patient should be on the Shielded Patient List (SPL)
- Incomplete vaccinations for shielded patients can be delayed EXCEPT the first dose of PPV23 and in the booster dose of PPV23 in certain groups.
- It is important that patients are concordant with their antibiotic prophylactic therapy
- Those who are not taking prophylactic antibiotics should have an emergency supply at home to take if unwell and instructed to do so by a clinician
- Patients with sickle cell disease and some thalassemia patients are considered extremely clinically vulnerable and are currently on the SPL. For the most up to date SPL check the NHS digital website.
- All patients reporting a new fever should be evaluated for bacterial as well as viral infection

For information about the full vaccination for absent or dysfunctional spleen please refer to the Green Book. NB: The vaccination schedule has recently been updated to no longer recommend additional Hib vaccination due to a long standing successful vaccination programme in children and because the risk of Hib disease is extremely low.