

Effective treatment with Tocilizumab in a COVID-19 patient on maintenance hemodialysis: A case report

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Case Report

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Abstract

Background: Coronavirus disease 2019 (COVID-19) is a rapidly spreading infective disease caused by the severe acute respiratory syndrome coronavirus 2 virus (SARS-CoV-2). The management of this disease remains a challenge particularly in certain subgroups of patients such in hemodialysis patients who have higher exposure rates due to the nature of their in-hospital care, and higher mortality due to their burden of comorbidities. Moreover, molecules used in the general population to treat COVID-19 lack data regarding their pharmacodynamics in the hemodialysis population.

Case presentation: We report a case of a 52-year-old patient with Von Hippel Lindau syndrome and end stage renal disease on hemodialysis who contracted COVID-19 infection. Due to the patient's rapidly deteriorating clinical status he was successfully treated with Tocilizumab, despite the lack of data concerning the use of this molecule in this population. The patient was later discharged after a long hospital stay and progressive clinical, biological and radiological improvement.

Conclusion: This sub group of patients should be carefully approached due to the unique nature of their comorbidities, and to their immune's system response to the virus itself and to novel therapies. Although few studies were available regarding the use of Tocilizumab in the dialysis population, its use proved to be effective and well tolerated in our patient.

Background

Since late December 2019 the world is witnessing a rapidly evolving healthcare emergency, manifesting as an unparalleled humanitarian and economic burden.

The novel Coronavirus disease (coronavirus disease 2019 or COVID-19) was first reported in Wuhan, a city in the Hubei province of China(1) and has since spread to 188 countries or regions resulting in an ongoing pandemic. As of late May 2020, over 5,200,000 cases and 330,000 deaths have been reported worldwide according to the World Health Organization situation reports.

It has been reported in multiple studies that old age, hypertension, diabetes, immunosuppression and cardiovascular diseases are risk factors associated with increased morbidity and mortality(2). These comorbidities are common in patients with end stage renal disease (ESRD) undergoing chronic hemodialysis explaining the higher mortality rate in this population raging from 13 to 30.5% in recent studies(3,4).

Case Presentation

A 51-year-old male patient presented to the emergency department for a two-day history of fever and cough. The patient is known to have ESRD on maintenance hemodialysis three times weekly at our center since late 2012. He is known to have Von Hippel- Lindau (VHL) disease with many of its systemic manifestations including hemangioblastomas of the brain and spine, retinal hemangioblastoma, bilateral

renal clear cell carcinoma leading to bilateral nephrectomy and adrenalectomy, and a serous cystadenoma of the pancreas. He also has a history of hypertension on multi drug therapy including an angiotensin receptor blocker, diabetes and coronary heart disease with ischemic cardiomyopathy, he underwent percutaneous coronary intervention to the left anterior descending artery 8 months prior to this admission. His last admission four months prior to this presentation was for ascending cholangitis treated with antibiotics and endoscopic drainage.

At the emergency department, the patient was looking ill, complaining of dry cough, dyspnea and fever. A high-resolution CT of the chest revealed multiple parenchymal consolidations associated with multifocal ground glass opacities. These findings were suggestive of a COVID-19 pneumonia in the setting of the pandemic, and the patient was admitted to our COVID-19 isolated floor unit pending PCR results.

Due to the patient's symptoms, imaging findings highly suggestive of COVID-19 disease and his rapidly deteriorating clinical status including high grade fever and increased oxygen requirements, he was started upon admission on Azithromycin, Hydroxychloroquine and Piperacillin/tazobactam.

Our center is not equipped with negative pressure dialysis facilities; this implied the patients transfer to the dedicated COVID-19 intensive care unit in order to have his dialysis sessions. Upon his admission to the ICU the patient presented with an APACHE score of 16 and a SOFA score of 13. He developed on day 7 of the illness a rapidly progressive respiratory distress leading to his urgent intubation, and the patient was started on hydrocortisone 50 mg QID and norepinephrine. His clinical status deteriorated with respiratory failure and diffuse patchy infiltrate present on imaging, we decided to treat him with 400 mg of Tocilizumab (HScore of 165) despite the lack of data concerning this molecule in the hemodialysis population.

Two days later the patient presented with a prolonged QT interval (503 ms) requiring the discontinuation of Azithromycine, and Hydroxychloroquine. On day 11 of the illness he was extubated, but intubated again on day 14 secondary to increased bronchial secretions caused by superimposed bacterial pneumonia leading to septic choc with increased dosage of norepinephrine and antibiotic step up to Meropenem.

On day 27 of the illness the patient presented with a fever indicating a second bacterial pneumonia which was later known to be secondary to *Stenotrophomonas Maltophilia* found in sputum and blood cultures, treated for a total of two weeks with Levofloxacin and Ceftazidime. He was extubated on day 34 of his illness.

Throughout these many complications a total of seven PCRs were performed and remained positive. On day 41 of the illness the patient was treated with ivermectin for a total of three days. Table 1 shows the evolution of the biological parameters.

The last positive PCR was on day 48 of his illness with a negative PCR 52 days after the onset of symptoms, adding up to a total of 52 days of viral shedding. Later, after a second negative PCR the

patient was transferred to our floor unit where he was rehabilitated, and discharged on day 69.

Discussion And Conclusions

Patients with CKD-5D are prone to infectious complications, sepsis being a major cause of mortality in hemodialysis patients after cardio vascular disease with an annual percentage of a 100 to 300-fold higher than the general population(5).

Both the innate and adaptive immunity are impaired in patients with ESRD with in-vitro evidence of decrease in T-cell proliferation attributed to impairment in APC's and TLR. Additionally a decreased expression of Bcl2 leads to increased apoptosis of B cell lymphocytes(6) but with no consequence on IgM and IgG secretion.

Hypercytokinemia is present in patients with ESRD secondary to decreased renal elimination along with increased secretion of pro inflammatory cytokines secondary to the continuous inflammatory state, oxidative stress, and uremic toxins(7). Interleukin 6 (IL-6) is one of the most studied pro inflammatory factors in uremic patients, its presence as a mediator of acute phase response, increases the risk of malnutrition, cardio vascular disease and mortality, and it has been discussed whether anti-cytokine therapy can play a role in this population regarding reversal of cardiovascular mortality(8).

By binding to its receptor (IL-6R), IL-6 system has a role in promoting an inflammatory state via its action on activation, recruitment and differentiation of lymphocytes. The early reports from Wuhan also showed increased levels of IL-6 in critically ill patients with COVID-19(9).

Tocilizumab, a monoclonal antibody targeting the IL-6R, previously approved for treatment of chimeric antigen receptor T cell-induced cytokine release syndrome (CRS) and in various rheumatoid diseases such as rheumatoid arthritis, resurfaced during the beginning of the COVID-19 pandemic. The rationale behind its use is extrapolated from promising data previously reported during the previous MERS and SARS pandemics.

Tocilizumab is a well-known molecule within the nephrology community, it has been used in desensitization protocols of kidney transplant recipients and It is recently gaining a more promising role in the treatment of chronic active antibody-mediated rejection in kidney transplantation(10).

Tocilizumab had not been studied in patients with a CrCl of less than 30 ml/min and neither on patients undergoing maintenance hemodialysis, and its use in this population was limited to case reports. M. Iwamoto et al. described in 2009 its successful use in a 64-year old woman with rheumatoid arthritis on hemodialysis (11). Early on during the COVID-19 pandemic, Hammani et al along with Ferrey et al presented with two clinical scenarios where Tocilizumab was used in hemodialysis patients to treat COVID-19. The first case led to a successful remission while the second patient was still in critical care at the time of the publication(12,13).

The use of a single dose of 400 mg of Tocilizumab was effective and well tolerated in our patient, who was afebrile 24 hours later with rapid improvement of biological and radiological parameters, with no directly related adverse effects.

Its use in this sub group of COVID-19 positive population should be further studied to better define its potential role in an overly stimulated immune system.

List Of Abbreviations

COVID-19: Coronavirus disease 2019

SARS-CoV-2: Severe acute respiratory syndrome coronavirus 2 virus

ESRD: End stage renal disease

VHL: Von Hippel Lindau

PCR: Polymerase chain reaction

ICU: Intensive care unit

APACHE: Acute physiologic assessment and chronic health evaluation

SOFA: Sequential organ failure assessment

APC: Antigen presenting cell

TLR: Toll like receptor

IL-6: Interleukin 6

IL-6R: Interleukin 6 receptor

CRS: Cytokine release syndrome

MERS: Middle east respiratory syndrome

SARS: Severe acute respiratory syndrome

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Written informed consent was obtained from the patient for publication of this Case report and any accompanying images. A copy of the written consent is available for review by the Editor of this journal.

Availability of data and materials

All data generated or analyzed during this study are included in this published article.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

NN performed the literature review and wrote the initial draft of the manuscript.

AC, SM, MK and SF assisted with the data collection and case presentation.

DC and HA assisted with drafting and editing of the manuscript. DC was the treating physician for the patient. All authors read and approved the final manuscript.

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Table

Measure	Reference range	Illness day 4	Illness day 7	Illness day 22	Illness day 56
White cell count (* 10 ⁹ /l)	4-9	5	5.1	15.8	3.9
Absolute neutrophil count (* 10 ⁹ /l)	2-7.02	3.11	3.27	14.6	2.51
Absolute lymphocyte count (* 10 ⁹ /l)	0.8-4.05	1.4	1.59	0.28	0.99
Hemoglobin (g/dl)	14-18	11.8	10.4	9	7.9
Hematocrit (%)	45-54	37	32.6	27	24.2
Platelet count (* 10 ⁹ /l)	150-400	111	80	106	171
C-reative protein (mg/l)	<3.5	62.2	242	28.4	66
Procalcitonin (ug/l)	<0.1	NA	38.3	2.6	NA
Lactic acid (mmol/l)	0.7-2.1	NA	1.1	NA	NA
Triglyceride (mmol/l)	<1.69	1.51	NA	2.89	NA
Ferritine (ng/ml)	30-400	651	2267	3337	NA
D-Dimeres (ug/ml)	<0.5	9.66	NA	20	NA
Fibrinogene (g/l)	2-4	3.51	NA	2.33	NA

Table 1: Evolution of the biological parameters

Figures

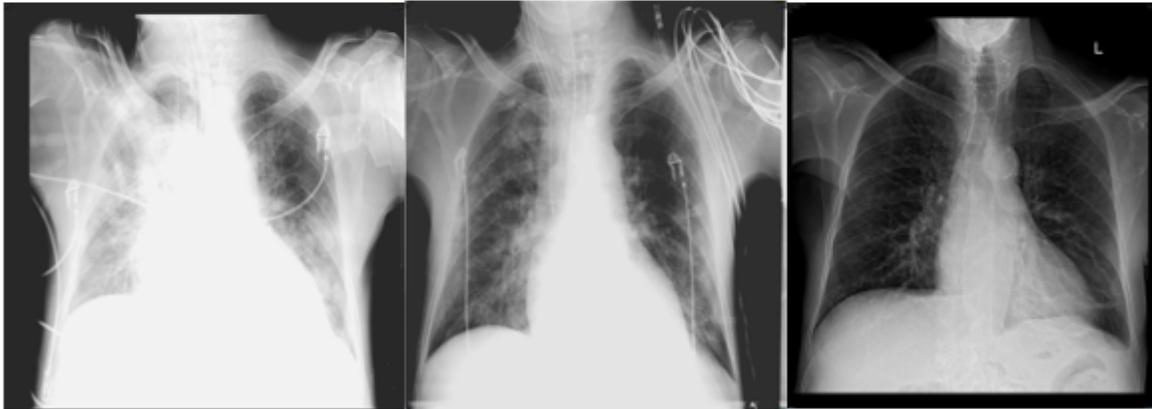
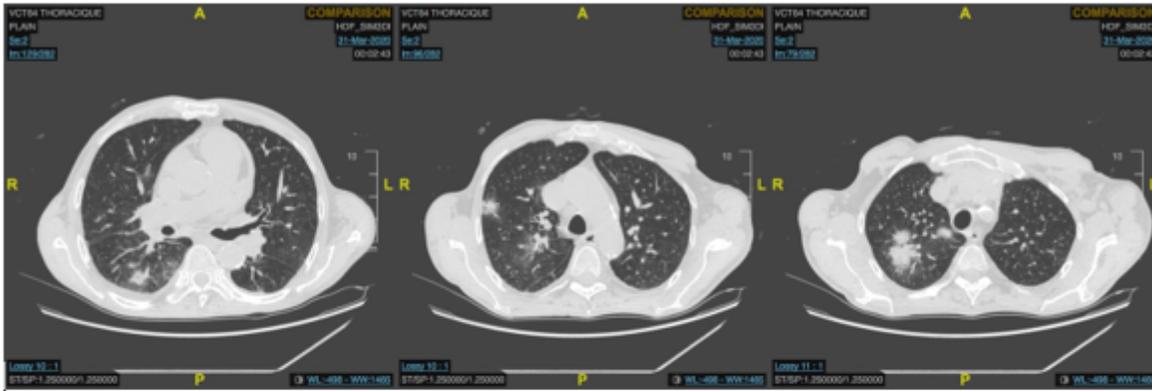


Figure 1

Fig 1: Radiographic imaging of the patient a- Axial chest CT on admission b- Chest radiograph upon first intubation c- Chest radiograph 3 days later d- Chest radiograph on discharge