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As both a clinician and educator, I have been monitoring the guidance concerning corticosteroid injections (CSI) during the COVID-19 pandemic closely. In mid-March I was alerted to a statement from a prominent MSK radiologist citing the potential increased risk to patients receiving CSI and recommending withdrawal of this treatment. This view quickly gained momentum and, within a week, CSI had been withdrawn across the UK.

As services re-emerge after lockdown, we need to question whether continued suspension of CSI has anything to do with the evidence or indeed the guidance - as I would argue that we have really not paid much attention to either up to now.

Let's take a quick look at the evidence first. The primary concern in all of this is the risk that the presence of steroid would suppress the patient's immune system and increase their susceptibility to COVID-19. A number of studies [1-9] were presented looking at possible increased infection risk with high dose or systemic steroids and this provided the basis for making some assumptions about the impact of CSI. It is now increasingly accepted that any increased risk to infection from low dose, single corticosteroid injections is primarily a theoretical one and the threat to patient safety has been greatly over-stated [10].

There is widespread unease about the re-introduction of CSI despite the flimsy evidence to which we have all been adhering to. In a small survey of clinicians I conducted, 81% said they would be unable to resume injection therapy practice for the foreseeable future. It might surprise you to learn that the guidance from NHS England [11], on which the CSP [12] has piggy-backed, has never advised withdrawal of CSI but recommended careful clinical reasoning and patient selection which, any competent clinician should be doing routinely anyway.

I fully concur with the following conclusion taken from a recent review of the literature [10]:

'When faced with uncertainty, it is understandable to remain circumspect. While the guidelines have not advocated an embargo on CSI, it appears that many practitioners and providers are reluctant to consider CSI as a treatment option during this pandemic. Such approach would deny patients a treatment that could alleviate pain and improve quality of life. In the current climate where the timing of reinstatement of elective surgery remains indeterminate, judicious use of CSI for many patients would delay, if not remove, their need for surgery.'

It will be necessary to review and update the information given to patients, incorporate some COVID-19 specific screening questions in the assessment and review the consent process to ensure the guidance is fulfilled but the current climate should not preclude clinicians from delivering treatment to the people who most need it.

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