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Diagnosing Long COVID: Rheumatologic Implications of 2024 Criteria

Ryan Quigley:
You're listening to *Living Rheum* on ReachMD, and this is an *AudioAbstract*. I'm Ryan Quigley and today we're spotlighting a commentary published in *Arthritis & Rheumatology* in July 2025 from Dr. Leonard Calabrese and colleagues. This article examines the National Academies' 2024 Diagnostic Criteria for long COVID, highlighting potential areas of concern for the rheumatology community.

But before we dig into this discussion, let's start with some background. Since the beginning of the pandemic, clinicians have observed that a subset of patients experience persistent or relapsing symptoms well after acute SARS-CoV-2 infection. This constellation of symptoms—often called long COVID or post-acute sequelae of COVID-19—has been linked to over 200 symptoms across multiple organ systems. But despite its prevalence, the absence of a unified definition has complicated both care and research for the disorder.

In response, the U.S. Department of Health and Human Services commissioned the National Academies to develop an inclusive, consensus-based diagnostic framework. That definition was released in 2024, with goals that include improving diagnostic consistency, streamlining access to care and benefits, and standardizing study populations.

But as Dr. Calabrese and co-authors point out, such broad inclusion criteria can cut both ways. Let's take a look at how.

Their first concern is the low specificity of the new definition. It allows for a diagnosis of long COVID without requiring confirmatory testing, a defined latency period, or even documentation of symptomatic COVID-19 at the time of infection. In practice, that means nearly any generalized symptom—such as fatigue, joint pain, cognitive fog, or sleep disturbance—can meet criteria, regardless of timing or clinical context.

That flexibility may be helpful in improving sensitivity in populations with higher prevalence, but it also raises the risk of diagnostic overreach, especially when distinguishing long COVID from symptoms of post-viral syndrome or rheumatologic disease. The authors emphasize that such broad inclusion may not serve patients well in cases where such symptoms lack a clear etiology.

The authors' second concern affects rheumatologists directly: it's the inclusion of newly diagnosed autoimmune diseases such as lupus, rheumatoid arthritis, and Sjögren's syndrome as part of the definition of long COVID. The National Academies state that a diagnosis of long COVID may include these diseases when they're newly identified following SARS-CoV-2 infection.

But here, the authors urge caution.

While some observational studies suggest a modest increase in autoimmune diagnoses post-infection, others show no significant association, or even inverse trends. Many of these studies rely on retrospective electronic health record data, which can be limited by coding inaccuracies, selection bias, and unmeasured confounders like healthcare access. There's also the issue of temporality as correlation does not imply causation.

From a clinical standpoint, the implication is significant. By labeling incident rheumatic disease as long COVID, providers may blur diagnostic clarity, complicate treatment pathways, or inappropriately attribute disease onset to infection. And perhaps just as importantly, it could confound research efforts by muddying case definitions and inclusion criteria for future trials.

That said, the authors don't dismiss the importance of continued research in this area. They acknowledge that COVID-19 can influence immune function by triggering low-grade inflammation, interferon signaling, or autoantibody production. But they argue that these changes alone are not diagnostic. More work is needed to determine whether such findings are pathogenic, transient, or clinically relevant.

So, what does this mean for rheumatologists?

First, it underscores the importance of clinical judgment when evaluating patients with post-COVID symptoms. The broad criteria may help patients access care, but careful assessment is needed to avoid over-attribution. Second, it highlights the need for better biomarkers and disease stratification—tools that can help distinguish idiopathic autoimmune disease from post-infectious syndromes that may follow different trajectories.

Finally, the authors remind us that as a specialty, rheumatology is well-positioned to lead in this space. Rheumatologists already care for patients with complex, multisystem diseases that overlap with long COVID symptomatology. Their clinical lens and research methods can contribute to shaping a more precise definition for long COVID, informing therapeutic strategies, and improving care models for this emerging patient population.

In the meantime, the authors call for ongoing education and engagement across the field—recognizing that our understanding of long COVID and its relationship to autoimmune disease is still evolving.

This has been an *AudioAbstract* for *Living Rheum*, and I'm Ryan Quigley. To hear this and other episodes in our series, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.

Reference:

Calabrese LH, Putman M, Sparks JA, et al. The National Academies' 2024 Diagnostic Criteria for long COVID: concerns that could affect the rheumatology community. *Arthritis Rheumatol*. 2025;77(7):785-788. doi:10.1002/art.43114