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Letter: immunotherapy for IBD patients in a SARS-CoV-2 endemic area—authors' reply

EDITORS,

We thank Waggershauser *et al* for their comments and interest in our case series reporting the incidence and clinical characteristics of COVID-19 cases among IBD patients in our IBD Unit in Madrid.[1,2]

They provided new data from a questionnaire on symptoms of respiratory tract infections, hospitalisations and SARS-CoV-2 swab test results in a cohort of IBD patients. The authors reported that the course of SARS-CoV-2 infections in IBD patients receiving immunotherapies was mild and uneventful. In relation to these findings, as part of our case series, we reported a case of COVID-19 in a 76-year-old man with terminal ileal Crohn´s disease, hypertension, diabetes and chronic liver disease. The patient was on maintenance therapy with azathioprine when severe COVID-19 was diagnosed with bilateral pneumonia needing hospitalisation. Although thiopurines have been associated with serious viral infections[3] the attending physician continued azathioprine in this patient, adding hydroxychloroquine (per protocol at the time for patients hospitalised with COVID-19). This approach was adopted in the belief that immunosuppressants may be beneficial to control the cytokine storm in response to viral infection, which bears some resemblance to the process in IBD flares.[4] This strategy to contain the hyper-inflammatory state appeared successful; markers of systemic inflammation (including IL-6, CRP, ferritin and D-dimer levels) dropped progressively, and the patient was discharged without subsequent complications. In case of worsening, this patient would have been a candidate for treatment with tocilizumab, but the increase in cases of gastrointestinal perforation and abscesses observed in a clinical trial with an experimental anti-IL-6 agent for Crohn's disease call into question the benefit of tocilizumab, which also targets IL-6, in this specific case.[5]

A recent review assessing the interaction between viral immunopathology and immunosuppressive and biologic drugs concluded that immunosuppressive therapy seems neither to have a major impact on infection with SARS CoV-1, MERS-CoV and SARS-CoV-2, nor to lead to a severe disease course in many cases.[6] Furthermore, evidence that TNF antagonist monotherapy was not associated with, and may even have a protective effect against, severe COVID-19[7] reinforces the need for trials evaluating these drugs for COVID-19.[8] In fact, a phase 2 trial of infliximab in COVID-19 has recently been registered.[9] Therefore, we agree that, since discontinuation of therapy is associated with an increased risk of IBD flare or worsening, we should recommend all our patients (without COVID-19) to continue the various immunosuppressants or biologic agents prescribed for their IBD.

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LINKED CONTENT

This article is linked to Taxonera et al and Szokodi papers. To view these articles, visit https://doi.org/10.1111/apt.15804 and https://doi.org/10.1111/apt.15897

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