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## Effect of COVID-19 lockdown on alcohol consumption in patients with pre-existing alcohol use disorder

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We agree with the Editorial in the July, 2020, issue of *The Lancet Gastroenterology & Hepatology*, which emphasised the concerning long-term implications of lockdowns implemented to flatten the epidemic curve of COVID-19 on the health behaviour of individuals with alcohol use disorder.<sup>1</sup> A complex interplay of heightened financial difficulties, social isolation, uncertainty about the future, and the redistribution of the health workforce and the disruption to clinical services could contribute to increased alcohol intake and relapse under lockdown conditions, and, subsequently, contribute to further liver-associated complications via direct injury or through late presentations to the appropriate services.<sup>1-5</sup> Lockdown is a complex social phenomenon that provokes different behavioural responses: a population survey of 1555 active drinkers in the UK identified that 21% increased alcohol consumption during the lockdown, while 35% reduced their alcohol intake.<sup>6</sup> The true effect of the lockdown on alcohol intake remains unknown because of a paucity of qualitative data.

2 months after lockdown was declared in the UK (March 23, 2020), we did a cross-sectional telephone survey of patients with pre-existing alcohol disorders registered since 2017 in the alcohol clinic of St Mary's Hospital, London. From May 21 to June 10, 2020, 322 (70%) of 462 patients from the database were contacted and 182 (57%) agreed to participate (appendix). The survey was done in English using a standardised questionnaire by two trained clinicians (JUK, AM).

Participants were mainly male (133 [73%] men, 49 [27%] women) and

of white ethnicity (141 [78%]), with a median age of 57 years (IQR 49–66). 42 (23%) of the 182 participants were hazardous drinkers and 71 (39%) were moderate-severe alcohol users before lockdown, as assessed by AUDIT score. Of the 182 participants, 43 (24%) reported an increase in their alcohol intake, with a mean increase in the AUDIT score of 5.7.6%, and a mean weekly consumption of 82.5 units (SD 78). 34 (19%) reported a decrease in their alcohol intake. Although some parameters such as age, mood, and some social conditions differed between those who had increased, decreased, or had an unchanged consumption of alcohol during the lockdown (appendix), a multivariate analysis identified only the pre-lockdown AUDIT score and percentage change of AUDIT score from before to during lockdown as factors associated with increased alcohol intake during lockdown.

69 (38%) patients were classified as abstinent before lockdown, with a mean abstinence period of 19.5 months (SD 22). Of this subgroup, 12 (17%) relapsed during lockdown. Mean AUDIT score within the relapse group at the time of our survey was 15.7 (SD 9.6), representing a 226% mean increase from before lockdown, with a mean weekly consumption of 48.8 units (SD 63) during lockdown. Of the 113 individuals who were previously drinking before the lockdown, 14 (12%) became newly abstinent since the beginning of lockdown.

Among all participants, 55 (30%) had either a virtual or face-to-face contact with the clinic during lockdown; 19 (44%) of the 43 individuals who had increased alcohol consumption had a clinic appointment, compared with 36 (26%) of the 139 individuals with decreased alcohol consumption or for whom consumption remained the same ( $p=0.035$ ; odds ratio [OR] 0.586, 95% CI 0.378–0.908). Of the subgroup of patients who had a virtual or face-to-face consultation during the lockdown,

13 (24%) had contact specifically with an alcohol specialist nurse. Univariate analysis revealed that those who had contact with a specialist nurse were more likely to become newly abstinent, compared with those who did not have contact (two [100%] of two vs two [12%] of 17;  $p=0.035$ ; OR 1.118, 95% CI 0.032–0.432); a positive trend was observed for reduced relapse during lockdown, occurring after alcohol nurse contact (six [18%] of 33 vs three [60%] of five;  $p=0.075$ ; OR 0.303, 95% CI 0.110–0.839).

We emphasise several points. First, lockdown causes different behavioural changes on alcohol intake, with about 20% of individuals increasing or decreasing their normal alcohol consumption. Although psychosocial distress has been well recognised as a risk of relapse and increased alcohol consumption,<sup>7</sup> the reduction might be associated with decreased financial ability and the decreased availability of on-site alcohol areas (eg, pubs or bars).<sup>2</sup> Second, we found no distinct protective factors for relapse, suggesting that pre-lockdown abstinence status is not protective against lockdown-related relapse. The mean duration of abstinence before relapse was long, which has been previously identified as a strong predictor of continuous abstinence.<sup>8</sup> Lockdown might overshadow this paradigm. Third, those who relapsed had a clinically significant average level of alcohol consumption of nearly 49 units weekly post-relapse, which is concordant with previous studies of a high risk of harmful drinking after relapse.<sup>9</sup> Finally, in a subgroup of patients who had clinical contact during lockdown, contact with an alcohol nurse specialist was a positive predictor for reducing relapse and improving new abstinence. Nonetheless, these findings should be interpreted with caution because of the small sample size of this subgroup. Our data represent a cross-sectional perspective of alcohol disorders during COVID-19 lockdown; any

See Online for appendix

further changes that might present if lockdown conditions change remain to be elucidated.

In summary, lockdown represents a risk factor for increasing alcohol consumption in people with alcohol use disorders and relapse for those who were previously abstinent. Those who do relapse are at a high risk of harmful drinking and require a tailored approach for follow-up and intervention. Support from alcohol liaison services could prevent relapse during lockdown.

We declare no competing interests.

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## IBD in the COVID-19 era: the value of international collaboration

At the beginning of March, 2020, there was a pressing need to better understand the risks associated with COVID-19 faced by patients with inflammatory bowel disease (IBD), particularly those on immunosuppressive medications. Early in the pandemic, the International Organization of Inflammatory Bowel Disease brought together our two groups from Mount Sinai (New York, NY, USA) and the University of North Carolina (Chapel Hill, NC, USA) that had been working on the same topic in parallel. We understood that this rapidly evolving situation needed timely data acquisition and analysis. In response, together we developed the Surveillance Epidemiology of Coronavirus Under Research Exclusion for Inflammatory Bowel Disease (SECURE-IBD) registry to monitor and report on COVID-19 outcomes occurring in paediatric and adult patients with IBD. This international, collaborative effort was developed in partnership with 38 international, national, and regional organisations.<sup>1</sup>

Developing the registry came with a unique set of challenges. One of the most important hurdles we faced was creating a case report form that requested enough information to adequately assess COVID-19 outcomes and demographic or disease factors, without overburdening busy clinicians. After many iterations, we arrived at a form that could not only be completed in under 5 min but also answer the most pressing clinical questions. To ensure that providers felt confident in the security and anonymity of the report, we included only de-identified data as per the HIPAA Safe Harbor De-Identification Standards. The database was easily accessible through a website and

stored on a secure web platform (REDCap version 10.0.15; Vanderbilt University, Nashville, TN, USA).

To raise awareness and encourage reporting of cases, we partnered with national and international organisations to promote the registry through professional listservs, social media, and society websites. We then organised an international advisory committee of leaders in IBD from across the world who provided advice on the registry design and analyses, as well as on networking and project promotion. We used webinars, Twitter, and Facebook Live events to engage the international gastroenterology community and to deliver preliminary results. This international, collaborative effort paid off: as of Aug 11, 2020, 2035 cases have been reported to the registry and 115 121 unique users have accessed the project website.

A major success of SECURE-IBD has been the rapid collaborative mobilisation of the IBD community worldwide. Key to this effort was the transparency and real-time (at least weekly) updating of raw aggregate data on the SECURE-IBD website. The website also directs providers and patients to national and international educational resources on COVID-19. The combination of open data sharing, emphasising that we are all in this together, and the collegiality and generosity of the many reporting providers were essential elements in building SECURE-IBD. Colleagues from University of Calgary (Calgary, AB, Canada) added an interactive map providing a visualisation of the SECURE-IBD data to the project website, modelled after the Johns Hopkins COVID-19 Dashboard.

To assist parallel efforts in other disease states, we directly consulted with colleagues starting similar registries and posted our study's case report form and protocol on the website to serve as a blueprint for other COVID-19 registries (eg, SECURE-Eosinophilic Esophagitis