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Conflicts of interest

The authors disclose no conflicts.

 Most current article

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The Adherence to Infusible Biologic Therapies in Inflammatory Bowel Disease Patients during the COVID-19 Pandemic: Is It Really a Problem?



Dear Editors:

We read with great interest the nationwide retrospective study by Khan et al¹ evaluating the adherence to infusible biologic therapies, defined as receiving an infusion within 10 weeks of the prior infusion, in patients with inflammatory bowel disease (IBD) during the current coronavirus disease 2019 (COVID-19) pandemic. The authors compared the adherence to infusion therapy between a cohort of patients with IBD who received infusible biologic therapies during COVID-19 and another cohort of patients with IBD who underwent the same therapies in 2019. They found that the adherence decreased from 84.6% in 2019 to 73.6% during the 2020 CoVID-19 crisis, thus recording a decrease in the weekly number of infusions in their center since late March 2020. Finally, this exploratory analysis also confirmed a significant association between nonadherence to biologics infusion and the subsequent risk of corticosteroid requirement.

To evaluate the impact of COVID-19 and the following lockdown on the routine activities of our gastroenterology unit, we collected data from all accesses for infusible biologic therapies to our infusion center between the January 8 and February 7 (before the lockdown) and between March 8 and April 7 (after

the lockdown and CoVID-19 breakout).² In contrast with Khan et al, we did not observe a particular reduction of activity compared with the prelockdown period (280 vs 263) and at the same time we did not observe an increase of corticosteroid need or hospitalization among our patients with IBD.²

Surely, this pandemic with the extraordinary measures to contain the viral spread captured the public attention and generated misconceptions and fears.³ To that end, a recent survey, conducted on a German cohort of 715 patients with IBD to investigate their perception of the emergency and their medication compliance, demonstrated that the fear was more pronounced in patients taking immunosuppressants. In particular, they were concerned about interactions between medication and COVID-19.⁴ Nevertheless, 96.4% of patients adhered to their medication schedule.⁴ Therefore, the rapid countermeasures adopted at many IBD centers, including ours, such as the implementation of telemedicine and distance education allowed to reassure patients with IBD about the lack of risk related to COVID-19 infection.^{4,5} For instance, at our center, 1 week before the infusion, patients were contacted by email to reassure them about the lack of risk in coming to the hospital and the benefit of continuing medical therapy. Moreover, the day before the infusion each patient was contacted by phone to confirm the appointment and to explain the measures adopted to decrease the risks for all patients entering the hospital (ie, triaging for potential COVID infection). Finally, a mobile phone number was provided to the patients in case of doubts or concerns. These experiences teach us that more contact and dialogue with patients with IBD is important to reassure them and also to provide the correct information and psychological support. We should explain to our patients with chronic diseases why it is important that they adhere to therapies which are relative safe and manageable despite the COVID-19 pandemic.⁶

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Reply. We appreciate the comments from Dr Barberio and colleagues¹ on our study reporting a significant reduction in adherence to infusion of biologics among US veterans with inflammatory bowel disease (IBD) following the declaration of national emergency for the Coronavirus Disease 2019 (COVID-19) pandemic. They shared interesting data from their own gastroenterology unit in Italy where they, in contrast to our report, “did not observe a particular reduction” in adherence to infusion of biologics after a COVID-19–related lockdown was put in place. They attributed this observation to “greater contact and dialogue” with patients with IBD.

There are important differences between the 2 analyses. Our analysis reported changes in the incidence of attending infusion sessions among thousands of patients actively receiving biologic infusion in a nationwide IBD population over a 10-week period, whereas the analysis by Dr Barberio and colleagues¹ reported changes in simple counts of patients attending infusion at a single gastroenterology unit over a 1-month period. Also, we used historic controls that accounted for month-to-month variations in infusion attendance incidence. Furthermore, differences in the clinical characteristics, expectations, and behavior of the patients between VA and non-VA health facilities and between the US and Italian health care systems could also have contributed to the different results between the 2 analyses.

It is unclear from their brief description whether the various measures to contact patients before the infusion admission represented a change from the usual care, and if so, to what extent. Nevertheless, we agree that the experience of Dr Barberio and colleagues suggests a potential role for enhanced patient communication/education efforts to improve adherence to essential clinical treatment during a pandemic. This represents an important area for future research.

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Conflicts of interest

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Correction



Gotfried J, Naftali T, Schey R et al. Role of cannabis and its derivatives in gastrointestinal and hepatic disease. *Gastroenterology* 2020; 159:62–80.

In Table 3 of the above article, under the “Key Results” column, (1) There is reference to CDAI scores when it should correctly be UC disease activity index. (2) There is reference to score reduction by 1 patient or 6 patients. The text should correctly say: Decrease in UC disease activity index of approximately 6 points and decrease in Mayo score of approximately 1 point.

Correction



Shah SC, McKinley M, Gupta S, et al. Population-based analysis of differences in gastric cancer incidence among races and ethnicities in individuals age 50 years and older. *Gastroenterology* 2020; 159: 1705–1714.e2.

In the above article, the originally published graphical abstract contained missing values. Also, in Figure 1, the legend incorrectly labeled panel (A) Noncardia and panel (B) Cardia. The correct labels are: (A) Cardia and (B) Noncardia.

The online version of the article has been updated with the corrected graphical abstract and legend to Figure 1.