Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Correspondence

Reply to comment: Screening for active COVID-19 infection prior to biologic therapy in IBD patients: primum *non* nŏcēre

Dear Editor,

We have read with interest the comments to our article [1] written by Festa et al "Screening for active COVID-19 infection prior to biologic therapy in IBD patients: let's not increase our uncertainty without reducing our concerns [2]" recently published on Digestive and Liver Disease. The authors criticized our suggestion to expand the screening commonly recommended prior to the beginning of biologic therapy in Inflammatory Bowel Disease (IBD) patients, to include SARS-CoV-2 RT-PCR and, when available, antibody testing.

Although available data do not support an increased risk of contracting COVID-19 infection in IBD patients, a recent report from Italy showed a case fatality rate of 8% and an hospitalization rate of 28% among 79 IBD patients with confirmed COVID-19 followed-up at 24 IBD referral units [3]. The British Society of Gastroenterology and the International Organization for the Study of Inflammatory Bowel Diseases (IOIBD) recommendation that IBD patients do not have to stop their current medications in order to prevent infection or adverse outcome with COVID-19 [4,5] has recently been incorporated in the expert commentary commissioned by the American Gastroenterology Association institute [6]. Considerations on specific drugs were also provided, although robust evidence on the impact of different immunosuppressive medications on IBD patients during COVID-19 outbreak are lacking. However, there was no specific guidance with respect to COVID-19 testing in patients starting immunosuppressive treatment. Festa et al listed some considerations, which we would like to address point by point. First, the authors underline the need "*to have in mind the strategies to adopt in case of positivity*". Currently, there is not a standard approach to adopt in case of COVID-19 positivity, in particular when it is necessary to start a biological therapy, and the decision should be carefully made case by case. In the event of a SARS-CoV-2 positivity, an informed decision can be made to either postpone the start of the biologic therapy by a few days or, if an immediate start is necessary because of a severe disease flare, a multidisciplinary approach with the involvement of infectious disease specialists and/or respiratory physicians should be considered. Indeed, any event occurring after the start of biologic would be better managed if all the information regarding the health status of the subject is known. Another important aspect to consider is the contribution of glucocorticoids to the risk of a negative outcome in patients with COVID-19 active infection [7], since they are used concomitantly with Infliximab during the induction regimen or often as a bridge therapy before induction to biologic drugs of different class. Second, the authors expressed concerns about the possibility that COVID-19 testing could result in a delay of starting biologic therapy in patients with moderate-severe activity. We are somewhat surprised by this consideration. All IBD centres should follow the recommended pre-biologic screening guidelines [8] which include latent tuberculosis infection (LTBI) testing and relevant viruses immunization status. These tests require days to be completed (e.g. interferon gamma release assay (IGRA) for LTBI) which is more than the time required to obtain the results from the current widely available rapid oropharyngeal swab tests (less than 24 hours) or serological tests (less than 6 hours). Third, the authors criticised the different approach between patients starting immunomodulatory therapies and those already receiving biological or immunomodulatory agents. We acknowledge that it remains uncertain whether the use of IBD immunosuppressive medications increase the risk for SARS-CoV-2 infection and subsequent COVID-19 [5] and that now data from SECURE-IBD, not available at the time of writing the manuscript, do not suggest an increased risk complications of COVID-19 in IBD patients on biologics. However, we did not rule out the opportunity of testing patients on biological therapies. Recently new insights on the contribution of pre-symptomatic and asymptomatic subjects with active infection into transmission dynamics have been highlighted [9]. Patients receiving immunosuppressive medications could have a delay in viral clearance and thus prolong their transmission potential. This could be particularly important given that most of these patients regularly attend infusion centres and in the near future control measures may be eased.

In conclusion, at the time when the understanding of transmission should be improved and active interventions strategies implemented, we strongly believe that all patients should be tested for SARS-COV-2 by oropharyngeal swab before starting immunosuppressive (and immunomodulatory) therapies to avoid potential complications and make informed decisions [1,10,11] in line with the "primum non nŏcēre" principle.

Authors contribution

Fabiana Zingone, MD, PhD: design of the study, writing of the manuscript, approving final version

Andrea Buda, MD: design of the study, writing of the manuscript, approving final version

Edoardo Savarino, MD, PhD: design of the study, writing of the manuscript, approving final version

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Declaration of Competing Interest

All authors declare no conflict of interest for the letter to the Editor titled “Reply to comment: Screening for active COVID-19 infection prior to biologic therapy in IBD patients: primum non nŏcēre”

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