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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Reply to comment: Asymptomatic screening for SARS COV-2 prior to commencement of biologic therapies in patients with inflammatory bowel disease - a potentially harmful practice

Dear Editor, we have read with interest the comments to our article [1] by Prentice et al. [2]. The authors mainly underlined the potential harms associated with asymptomatic screening for SARS CoV-2 prior to commencement of biologic therapies in IBD patients without a strong evidence base to dictate subsequent practice on the return of a positive test.

We agree that available data do not strongly support an increased risk of contracting COVID-19 infection in IBD patients or a higher risk to develop complications in case of infection. On the other hand, there are studies suggesting a case fatality rate of 8% and a hospitalization rate of 28% among 79 IBD patients with confirmed COVID-19 followed-up at 24 IBD referral units [3]. Moreover, data from the SECURE registry observed that 7% of patients with IBD may develop severe COVID-19, 31% are at risk of hospitalization, and there is a 3% case fatality rate [4]. These numbers suggest that until our understanding on the impact of SARS CoV-2 on IBD will improve, a prudential strategy should be pursued in order to limit unnecessary risks for our patients [5,6]. In keeping, the last ECCO taskforce, providing guidance on the most appropriate care to adopt during the pandemic, confirms the need to test all IBD patients for SARS-CoV-2 if there is the need to start biologics for an IBD flare, particularly if glucocorticoids are already taken by the subjects [7].

Second, the authors expressed concerns about the possibility that COVID-19 testing could result in delaying biologic treatment and therefore perpetuating IBD disease activity and systemic corticosteroid use. From our perspective, it is difficult to understand how a rapid oropharyngeal swab test (less than 24 hours) or serological test (less than 6 hours) could delay the start of treatment, particularly considering that screening examinations (i.e. latent tuberculosis infection testing) carried out in parallel may require days before obtaining the final results. Thus, testing time should not be part of the problem in this particular setting.

Third, the authors pointed out the suboptimal accuracy of serological tests for SARS CoV-2 detection. We acknowledged the current limitation of this diagnostic method and, indeed, our screening algorithm recommends the use of nasopharyngeal swab, while serological antibody tests should be a useful supplement to RNA or antigen detection. On the other hand, serological test may provide further insights of the kinetics on the virus and additional data to implement strategies for preventing transmission and diffusion of the infection.

In conclusion, we believe that after about 6 months from COVID-19 outbreak, our knowledge is still limited and therefore we should continue to manage our patients with caution, trying to avoid complications and make informed decisions. Thus, we still believe that all patients should be tested for SARS-COV-2 by oropharyngeal swab before starting immunosuppressive (and immunomodulatory) therapies.

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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