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## Serological response rates after SARS-CoV-2 vaccination are adequate in most IBD patients, but durability may be a concern



COVID-19 vaccination effectively reduce the risk adverse outcomes, but concerns have been raised about vaccine effectiveness in immunocompromised individuals. In the case of inflammatory bowel disease (IBD), there have been concerns about the rate of seroconversion after vaccination and the durability of the response. The existing literature is heterogeneous with regards to patient IBD characteristics and vaccination type and schedule.

To help address these questions, investigators conducted a systematic review and meta-analysis that included 46 studies<sup>1</sup>. In 31 studies with 9,447 subjects who were completely vaccinated, the pooled seroconversion relative risk was 0.96 (95%CI, 0.94-0.97), and was higher for mRNA vaccines (0.97, 95%CI 0.96-0.98) than for adeno-associated vaccines (0.87, 95%CI: 0.78-0.93). The pooled seroconversion rates were similar regardless of IBD therapy, and ranged from 0.93 to 0.99. Most studies assessing durability reported a decay in antibody titers after 4 weeks from vaccination, and this appeared to be accelerated in those on anti-TNF agents, immunomodulators or their combination. However, the pooled relative risk of breakthrough COVID-19 infections in vaccinated patients with IBD was not significantly different from that of vaccinated controls. In the 2 studies that reported a third (booster) vaccine dose, the rate of seroconversion approached 100%.

These findings provide reassurance that IBD patients benefit from complete COVID-19 vaccination similar to healthy controls, but the accelerated decrement in antibody titers warrants consideration of a booster dose.

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## Long-term therapy after successful induction with budesonide oral suspension helps maintain remission in patients with EoE



The long-term management of eosinophilic esophagitis (EoE) may be challenging. Most studies have focused on short-term treatment outcomes, and while guidelines recommend maintenance therapy in those who initially respond to topical corticosteroids, there are few supporting data.

Here, Dellon and colleagues<sup>2</sup> randomized 48 patients who had fully responded to a 12-week induction course of budesonide 2 mg BID oral suspension to continuation of therapy or to placebo, for 36 weeks. In this arm of the study, the primary outcome was the rate of relapse by week 36, defined as  $\geq 15$  eosinophils/hpf and  $\geq 4$  days of dysphagia over 2 weeks. A separate arm included 106 patients who had either a partial response or no response to induction, and 65 who had received placebo during induction. These patients received budesonide for 36 weeks, and the proportion with complete response determined after a total of 52 weeks. In the primary analysis, the proportion of patients randomized to placebo experienced relapse at a numerically higher rate than those who continued budesonide (43.5%

vs 24.0%;  $p=.13$ ). This reached statistical significance in a per-protocol analysis. In the second arm, about 13% of the 106 patients with previous partial or no response did subsequently fully respond. Budesonide therapy was well-tolerated; candidiasis-related events occurred in 17 patients overall and were mild to moderate, and abnormal adrenocorticotrophic hormone stimulation tests were reported in 5%.

Overall, the findings are supportive of continuing budesonide topical therapy in patients with EoE who had good response to initial induction.

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## Inappropriate forceps polypectomy: Frequent but fixable



The US Multi-Society Task Force (USMSTF) on Colorectal Cancer recommends cold snare polypectomy for lesions 6-9 mm, and against forceps polypectomy for most diminutive lesions ( $\leq 5$  mm) mostly due to high rates of incomplete resection. The prevalence of this inappropriate practice, and whether it is reversible, is not well characterized.

In this retrospective analysis conducted at 2 US health care systems, investigators assessed the prevalence of inappropriate polypectomy, defined as the proportion of non-diminutive polyps removed with forceps<sup>3</sup>. A post-hoc analysis varied polyp size cutoff to 2 mm, based on a USMSTF provision allowing the use of forceps for some polyps  $\leq 2$  mm that are technically difficult to remove with a snare. The effect of an intervention including education and financial incentives was assessed.

Among 9,968 colonoscopies with polypectomy performed by 42 endoscopists, the prevalence of inappropriate forceps polypectomy was 8.5%. The rate varied from 0% to 29.2% per endoscopist, and decreased from 11.4% to 5.3% overall after the intervention (adjusted odds ratio 0.34, 95% CI 0.30-0.39). Most inappropriately resected polyps were 5-6 mm in size. In the post-hoc analysis varying polyp size cutoff to 2 mm, the prevalence of inappropriate polypectomy was 50% and decreased to 43% after the intervention.

Complete polyp resection is one of the core elements of high-quality colonoscopy, and effective colorectal cancer prevention. Inappropriate forceps polypectomy appears to be a prevalent practice, but is fortunately amenable to corrective measures.

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### Vascular liver disease and vulnerability to COVID-19 infection



**P**atients with chronic liver disease, especially those with decompensated cirrhosis, are at higher risk for hospitalization and

death from COVID-19 infection. Patients with chronic liver disease are heterogeneous, and the outcome of COVID-19 in different groups is not well known.

In this observational study from Spain and France, 986 patients with vascular liver disease (VLD) were identified, including 274 with portosinusoidal vascular disease (PSVD), 539 with non-cirrhotic splanchnic vein thrombosis (SVT) and 155 with Budd Chiari syndrome (BCS)<sup>4</sup>. The rates and outcomes of infection were compared to those of the general population.

Compared to the general population infection rate of 6.5%, infection prevalence was significantly higher for PSVD (19%) and SVT (14%) patients, but not significantly different for BCS (5%). Disease course was more severe for VLD patients compared to the general population, with higher hospitalization (14% vs 7.3%,  $p < 0.01$ ), ICU admission (2% vs 0.7%,  $p < 0.01$ ) and COVID-19-related mortality rates (4% vs 1.5%,  $p < 0.05$ ). Previously decompensated disease (manifested by ascites or hepatic encephalopathy) was predictive of further hepatic decompensation after infection.

Patients with VLD, and specifically those with PSVD and SVT,

appear vulnerable to COVID-19 infection and a more severe course, and should be targeted for preventive efforts.

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### References

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