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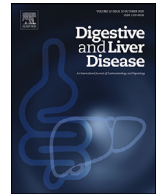
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Correspondence

Screening for active COVID-19 infection prior to biologic therapy in IBD patients: Let's not increase our uncertainty without reducing our concerns



Dear Editor,

We have read with interest the article of Zingone et al. "Screening for active COVID-19 infection and immunization status prior to biologic therapy in IBD patients at the time of the pandemic outbreak" recently published on *Digestive and Liver Disease* [1]. The authors, using a pragmatic approach, suggest updating the screening commonly recommended prior to the beginning of biological therapy in Inflammatory Bowel Disease (IBD) patients, adding SARS-CoV-2 RT-PCR and, when available, antibody testing. The authors do not recommend the same screening in those IBD patients who are already receiving scheduled biological treatment. The rationale of this proposal is based on the speculation that asymptomatic SARS-CoV-2 infected subjects might develop a more aggressive viral disease when exposed to biological agents. In our opinion, this proposal deserves discussion as it raises some considerations.

The first consideration is methodological. As a general rule, when carrying out a diagnostic test it is necessary to have in mind the strategies to adopt in case of positivity or negativity of the test. This is the reason why, for example, we determine HBV status before starting biologic therapy. In fact, according to the results of the test, we plan different strategies: HBV vaccination in all seronegative patients, and anti-viral agents in patients who are HbsAg positive, regardless of the degree of viremia. For COVID-19, at present, neither a vaccine nor antiviral treatment is available. Therefore, screening for SARS-CoV-2 infection prior to biologic therapy would only lead to quarantine positive patients deferring the start of biologic treatment for at least 2–3 weeks.

This leads to a second consideration. Patients who require biologic treatment do so because of moderately to severely active disease, and we believe that delaying biologic therapy might even be counterproductive, if we consider that it could indeed be active IBD to contribute to the development of severe COVID-19. While the characteristics of COVID-19 in IBD patients are currently unknown, preliminary data suggest that active IBD is associated with negative outcomes, including pneumonia and death, whereas concomitant therapy with biologics and immunosuppressants might not be associated with worse COVID-19 prognosis [2]. Therefore, our priority for IBD patients with active disease should be to offer effective therapy to induce and maintain remission and to avoid disease flares.

Finally, we believe that IBD patients who are candidate to biologic therapy should not be treated differently than patients who are already receiving biological or immunodulatory agents. At present there is no evidence suggesting that SARS-CoV-2 infection occurs more frequently in IBD patients than in the general population [3–5]. Therefore, we can speculate that the probability of detecting a positive SARS-CoV-2 RT-PCR in an asymptomatic subject is the same in IBD patients candidate to biologic therapy and in those already receiving scheduled treatment. Therefore, theoretically, if we believe that exposure to biological agents is to avoid in all SARS-CoV-2 positive IBD patients, we should apply the screening both prior to the commencement of biologic therapy, with the aim to postpone the treatment, and during scheduled treatment, with the intent to discontinue the treatment.

Do we have enough evidence to take such important decisions? In absence of evidence-based-data to support decision making process, major Gastrointestinal Societies such as the British Society of Gastroenterology (BSG), Crohn's and Colitis Canada (CCC), European Crohn's and Colitis Organization (ECCO), and the International Organization for the Study of Inflammatory Bowel Disease (IOIBD) have proposed empiric guidelines for management of IBD patients during COVID-19 outbreak [6,7]. Continuing IBD-specific treatment is always recommended because the risk of a disease flare is considered higher than the uncertain risks of COVID-19 severity. In particular, biologic treatment with unchanged dosing schedule should be continued and starting biologic therapy should not be delayed preferring, if possible, subcutaneous administration, in order to favor social distancing, and using caution with initiating combination therapy.

In conclusion, even if there is major concern regarding a possible increased risk of severe COVID-19 in IBD patients receiving immunosuppressive or biologic medications, in absence of evidence-based data we consider inappropriate a systematic screening for SARS-CoV-2 infection prior to biological therapy because this would increase our uncertainty without reducing our concerns.

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