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### Authors' reply

We thank Meixuan Li and colleagues for their interest in our study<sup>1</sup> and for highlighting an interesting topic regarding network meta-analyses and the ranking methods used in many of them.

Surface under the cumulative ranking (SUCRA) curves have become a popular ranking method in network meta-analyses.<sup>2</sup> However, as Li and colleagues point out, SUCRAs should be interpreted with caution for several reasons.<sup>3,4</sup> One of the most important reasons is that SUCRAs can be derived from studies in which the certainty of the evidence is low or very low. Hence, SUCRAs do not consider that chance might explain differences between treatments.

In our study, the inclusion criteria and the quality analysis that followed GRADE recommendations allowed us to include studies with at least a moderate-to-high level of confidence in their results, which could have decreased the chance of SUCRA misinterpretation. Nevertheless, this might not be enough to reduce bias, and the approach suggested by the authors to rank treatments and to reduce bias in SUCRA interpretation is interesting, although bias can still occur. Furthermore, there is no consensus on clinically meaningful differences in SUCRA values between different interventions,<sup>5</sup> which makes SUCRA rankings less relevant.

Finally, we believe it is essential to highlight that appropriate interpretation of network meta-analyses implies reviewing both direct and indirect comparisons, the network meta-analysis estimates, and their associated certainty estimates. SUCRA values and their visual display, when taken together with these other elements, can help in the interpretation of network

meta-analysis results. However, given their intrinsic limitations, we strongly suggest caution in interpreting the results of our study solely on the basis of SUCRA values and rankings.

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## Uptake of third doses of SARS-CoV-2 vaccines among people with inflammatory bowel disease in Ontario, Canada

Patients with inflammatory bowel disease (IBD) are often treated with immunosuppressive medications, which are associated with decreased antibody response to initial SARS-CoV-2 vaccination and waning antibody levels following a second dose.<sup>1,2</sup> The province of Ontario, Canada began offering third doses of SARS-CoV-2 vaccines to priority groups, including individuals with IBD on immunosuppressive therapy, beginning Sept 14, 2021,<sup>3</sup> followed by everyone aged 18 years and older on Dec 20, 2021.<sup>4</sup> We describe and compare vaccine uptake in people with and without IBD as of Jan 9, 2022.

We used health administrative data from Ontario, Canada for this population-based retrospective cohort study. Data include demographic characteristics, health-care encounters, and SARS-CoV-2 vaccinations for all provincial residents eligible for universal health-care coverage (>99% of the population). We identified all patients with IBD aged 18 years or older living in Ontario as of Sept 1, 2021 using validated algorithms<sup>5,6</sup> and compared them with people without IBD. Vaccination status was obtained from COVaxON, a comprehensive registry containing information on vaccine product, date of administration, and dose number for all vaccines administered in the



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province. COVaxON also includes out-of-province vaccinations reported to local public health units.

We determined overall and age-specific weekly cumulative incidence of first, second, and third doses of vaccination against SARS-CoV-2. We calculated the relative risk (RR) and corresponding 95% CI of vaccination. Third doses were assessed in the full population and among those with two doses. Analyses were done with SAS version 9.4 and R software.

Among 107 059 patients with IBD, 89.9% had one dose of a SARS-CoV-2 vaccine, 88.6% had two doses, and 58.3% had three doses as of Jan 9, 2022. Among 12 145 893 individuals without IBD, 85.6% had one dose, 83.8% had two doses, and 44.3% had three doses (RR for third doses 1.32, 95% CI 1.31–1.32; appendix). Among individuals with IBD, those between 18 and 39 years of age were least likely to receive a third dose (41.4%) but this age group had the highest uptake of third doses relative to the general population (RR 1.47, 95% CI 1.45–1.49).

In conclusion, in Ontario, Canada, where universal vaccination is available, there is higher uptake of third doses of SARS-CoV-2 vaccines among patients with IBD relative to the general population, but coverage remains suboptimal. Although the number of people with third doses is climbing, we expect these rates to plateau in both populations. As with first and second doses, we expect patients with IBD to have higher uptake of third doses than those without IBD. Efforts should be made to understand reasons for third dose vaccine hesitancy in patients with IBD, particularly in the Omicron era.

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See Online for appendix