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.

and resources to contribute to viral hepatitis elimination. The ambitious strategy aims for a 95% reduction in the number of new infections by 2030 compared with 2015, and a 65% reduction in the number of deaths. This will require a major increase of diagnosis and treatment coverage (by 90% and 80%, respectively), especially in low-income and middle-income countries, which carry the greatest burden of infection and disease.[2] Viral hepatitis is a major cause of mortality, mostly from cirrhosis and liver cancer, accounting for an estimated 1·4 million deaths globally each year, which is more than HIV or malaria.[2] By 2040, deaths from viral hepatitis worldwide are even projected to exceed those from HIV, tuberculosis, and malaria combined.[3]

The 2030 WHO viral hepatitis elimination goals were directly informed by a UK research group[4,5] and additional research groups from the UK, in collaboration with international researchers, made major contributions to viral hepatitis elimination strategies.[6] Beyond the fact that this budget cut will undermine the UK leadership in global health, including viral hepatitis, this decision will affect social justice and health equity in the COVID-19 era, when nations need more solidarity than before. Following previous open letters signed by hundreds of UK and global health organisations, we call upon the UK Government to urgently reconsider its ODA budget commitment.

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SARS-CoV-2 vaccination in immunosuppressed patients with inflammatory bowel disease: should our approach change?

Since the publication of the British Society of Gastroenterology (BSG) Inflammatory Bowel Disease (IBD) section position statement on SARS-CoV-2 vaccination,[1] developments concerning vaccine safety have prompted the BSG to review its guidance.

Concerns have arisen with the well-publicised association between the ChAdOx1 nCoV-19 (Oxford/AstraZeneca) vaccine and very rare reports of serious thromboembolic events, including cerebral venous sinus thrombosis, with concurrent thrombocytopenia.[2] There have been similar reports with the JNJ-78436735 (Johnson & Johnson) vaccine in the USA. This news will be of particular interest to patients with IBD, who are at increased risk of venous thromboembolism, especially during active disease.[3,4]

Based on data from over 20 million people having received a first dose of the ChAdOx1 nCoV-19 vaccine, the UK Medicines and Healthcare products Regulatory Agency (MHRA) reports the risk of such thromboembolic events at just over ten per million people vaccinated, with a slightly higher risk in younger individuals.[5] The MHRA guidance[5] now states that individuals under 40 years of age, without underlying conditions that put them at higher risk of severe COVID-19 disease, should be offered an alternative COVID-19 vaccine in preference to ChAdOx1 nCoV-19 vaccine, where it will not delay vaccination unduly.

By comparison to the risk of vaccination, the risk that a person will develop a deep venous thrombosis from a single long-haul flight is greater than one in 5000 and the risk of cerebral venous thrombosis in patients with COVID-19 infection is around four times higher than following the ChAdOx1 nCoV-19 vaccine.[6] The observed thromboembolic events associated with vaccination are thought to be idiosyncratic and mechanistically may be linked to development of antibodies to platelet factor 4. Other than in very specific pro-thrombotic conditions (patients with a history of cerebral venous sinus thrombosis, acquired or hereditary thrombophilia, heparin-induced thrombocytopenia, or antiphospholipid syndrome), the MHRA does not advise avoiding use of the ChAdOx1 nCoV-19 vaccine. We also note that in clinically extremely vulnerable groups and immunosuppressed adult patients with IBD, early vaccination remains the priority, irrespective of age or vaccine type.

We would like to reiterate the firm reassurance issued by the MHRA and other regulatory authorities regarding the ChAdOx1 nCoV-19 vaccine. Furthermore, with data now emerging from the CLARITY IBD study demonstrating attenuated immunogenicity to single dose COVID-19 vaccination in systemically immunosuppressed patients with IBD,[7] we would like to re-affirm the

importance of completing the full vaccination schedule when a second dose is offered, and we strongly recommend that UK health policy makers update their guidance to avoid the extended 12 week dosing regimen in immunosuppressed patients.

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