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COVID-19 in the IBD population: The need for correct nomenclature

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To the editor,

We read with great interest the article by Attauabi *et al*. in which they describe COVID-19 prevalence and outcomes in IBD patients in a Danish population-based cohort.[1] We commend the authors for establishing a population-based setting as this adds to a better understanding of potential risk factors and implications of COVID-19 for the IBD population.

However, we also would like to emphasise the importance of using correct nomenclature. Initially, as testing capacity was limited, predominantly people with COVID-19 associated symptoms were tested for SARS-CoV-2 infection. As a result, SARS-CoV-2 infection was used as a surrogate for COVID-19 in most studies. The indication for SARS-CoV-2 testing has changed since the beginning of the pandemic. We find that expansion of testing capacity has led to SARS-CoV-2 testing in people without symptoms, for instance in the context of contact research. This has also been acknowledged by Attauabi *et al*. in their article. Moreover, a recent study by Norsa *et al.* found that more than 1 in five (21%) IBD patients on biologic treatment in the Bergamo region, which was the European epicentre of SARS-CoV-2 infections, had been exposed to SARS-CoV-2. More than half of those patients (58%) were asymptomatic.[2] These numbers imply that the incidence of SARS-CoV-2 infections and the possible development of COVID-19 are different. In this light, gathering epidemiological data during this pandemic necessitates stringent application of definitions of this new disease.

Consensus about the definitions of this new disease, following ambiguity after discovery, have been reached. The virus was named by the international Committee on Taxonomy of Viruses (ICTV) as Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2). The disease caused by SARS-CoV-2 infection was defined as coronavirus disease 19 (COVID-19) by the WHO in the International classification of Diseases (ICD).[3] Hence, identification of SARS-CoV-2 in a patient and the diagnosis of COVID-19 should not be regarded as being equal. Adhering to only a PCR-confirmed presence of SARS-CoV-2 as a surrogate for COVID-19 could potentially lead to an overrepresentation of COVID-19

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cases and consequent relative risk for the IBD population. COVID-19 should therefore only be diagnosed in the presence of COVID-19 associated symptoms.

Although Attauabi *et al*. provided us with information on the prevalence and risk of SARS-CoV-2 infections for IBD patients rather than the true prevalence of COVID-19, the presented data and the population-based approach are still very informative and valuable. In order to be able to identify international differences, ensure generalizability, and learn from each other's data in this ongoing pandemic, we believe that epidemiological data should be presented in a standard format, preferably based on the internationally accepted nomenclature.

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