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.

Conflicts of interest
SCN is the scientific co-founder of GenieBiome Ltd, and the Chinese University of Hong Kong holds a provisional patent for A Synbiotic Composition for Immunity. FZ discloses no conflicts.

Most current article

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Should We Continue or Discontinue Inflammatory Bowel Disease Medication in Patients With Coronavirus Disease 2019?

Dear Editors:

We read with great interest the study by Ungaro et al,[1] "Impact of Medications on COVID-19 Outcomes in Inflammatory Bowel Disease: Analysis of More Than 6000 Patients From an International Registry." The authors compared the association between inflammatory bowed disease (IBD) medications during coronavirus disease 2019 (COVID-19) diagnosis and COVID-19 adverse events in the Surveillance Epidemiology of Coronavirus Under Research Exclusion (SECURE)-IBD database and showed that the prognosis of patients receiving steroids for IBD at the time of COVID-19 diagnosis was poor. In addition, the authors suggested that use of IBD medications, specifically tumor necrosis factor (TNF) antagonists, interleukin (IL) 12/23 antagonists, and integrin antagonists, may be a favorable prognostic factor for COVID-19.

However, the authors noted that measurement bias may occur if patients voluntarily discontinued their medication. SECURE-IBD has not accumulated real data on the withdrawal or postponement of IBD medication during the COVID-19 pandemic. The International Organization for the study of Inflammatory Bowel Disease (IOIBD),[2] European Crohn's and Colitis Organisation (ECCO)-COVID Taskforce,[3] and JAPAN IBD COVID-19 Taskforce[4] have provided guidelines on the continuation or withdrawal of IBD medications in patients with COVID-19 based on transitional evidence. However, the correct method of continuation/withdrawal of medications remains unclear. This is because only a few reports have been published on the clinical outcomes of IBD patients with COVID-19 who have stopped their IBD medications.

A retrospective multicenter registry study of Japanese patients with inflammatory bowel disease with COVID-19 (Japan COVID-19 surveillance in inflammatory bowel disease [J-COSMOS], UMIN000040656) has collected data regarding IBD disease activity, medications at COVID-19 diagnosis, withdrawal during COVID-19, and outcome of COVID-19.[5] We performed an interim analysis of the risk of postponing/discontinuing IBD medications during concomitant COVID-19 in 187 patients enrolled in J-COSMOS from June 2020 to October 2021. Of the 187 patients, the diagnosis of patients was ulcerative colitis in 104, Crohn's disease in 74, IBD unclassified in 3, and intestinal Behçet's disease in 6. First, we found that the percentage of Japanese patients with IBD and severe COVID-19 based on the World Health Organization classification was 7%. No deaths were recorded.

In this survey, among 144 patients receiving mesalamine at the time of COVID-19 diagnosis, 7.9% (11 of 140) of patients who continued it and 25% (1 of 4) of those who discontinued it had severe COVID-19. Of 57 patients receiving thiopurines, 3.6% (1 of 28) of patients who continued them and 3.4% (1 of 29) of those who discontinued them had severe COVID-19. In addition, none of the 48 patients who continued TNF inhibitors had severe COVID-19, and 3.8% (1 of 26) of the patients who discontinued them had severe COVID-19. The Fisher exact test showed no significant difference between the continuation and discontinuation of IBD drugs and COVID-19 severity (Supplementary Table 1). No patient receiving budesonide, ustekinumab, vedolizumab, or tofacitinib for IBD at the time of COVID-19 diagnosis had severe COVID-19. Furthermore, we examined whether continuation and discontinuation of IBD medications could contribute to worsening IBD clinical activity based on the partial Mayo score or the Harvey-Bradshaw Index. We found that neither continuation nor discontinuation of any medication during COVID-19 affected the exacerbation of IBD activity (Supplementary Figure 1). Meanwhile, 6.1% (10 of 163) of patients with IBD who continued medication had mild exacerbation of disease activity. Our current registry indicates that the continuation or discontinuation of IBD medications does not contribute to COVID-19 disease outcomes.

Despite the significance of our data, the limitation are (1) the number of IBD patients with COVID-19 in Japan was small, (2) we did not collect any data regarding when IBD medications were stopped or restarted and how long the patients with IBD had COVID-19, and (3) the number of patients with severe COVID-19 was too small to analyze the confounding factors of the relationship between continuation or discontinuation of IBD medications and COVID-19 severity.

In summary, our interim data suggest that neither continuation nor discontinuation of IBD medications affects COVID-19 severity. In addition, discontinuation of IBD medications did not contribute to flares of IBD during COVID-19. The SECURE-IBD and J-COSMOS data show 3 factors are implicated in the continuation or discontinuation of IBD medications in IBD patients with COVID-19: severity of COVID-19, IBD refractoriness, and type of IBD medications. Therefore, further accumulation of real-world data is required to manage IBD during the COVID-19 pandemic.

Supplementary Material

Note: To access the supplementary material accompanying this article, visit the online version of *Gastroenterology* at www.gastrojournal.org, and at https://doi.org/10.1053/j.gastro.2022.03.008.

YUKI HAYASHI
HIROSHI NAKASE
Department of Gastroenterology and Hepatology
Sapporo Medical University of Medicine
Sapporo, Japan

TADAKAZU HISAMATSU
Department of Gastroenterology and Hepatology
Kyorin University School of Medicine
Tokyo, Japan

J-COSMOS GROUP

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Conflicts of interest
The authors disclose no conflicts.

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Correction

Patel SG, May FP, Anderson JC, et al. Updates on Age to Start and Stop Colorectal Cancer Screening: Recommendations From the U.S. Multi-Society Task Force on Colorectal Cancer. Gastroenterology 2022;162:285–299.

In the first paragraph of the above article, which was published jointly in the January 2022 issues of *Gastroenterology* (Gastroenterology 2022;162:285–299), *Gastrointestinal Endoscopy* (Gastrointest Endosc 2022;95:1–15), and *American Journal of Gastroenterology* (Am J Gastroenterol 2022;117:57–69), in the section titled "Balance of Benefits and Harms of CRC Screening in Persons Under Age 50," the sentence "Although the incidence and mortality rates used in this updated report encompassed all colorectal tumors (adenocarcinoma and neuroendocrine),[15] as pointed out by Fields et al[58] and reviewed above, the 40–49 year old group was largely unaffected by isolating adenocarcinomas from neuroendocrine tumors" requires correction. The sentence incorrectly suggests that CISNET modelers included both adenocarcinoma and neuroendocrine tumors in analyses supporting USPSTF 2021 recommendations. In fact, the CISNET models excluded carcinoid/neuroendocrine tumors as outlined in their detailed report[1] and a separate letter to the editor.[2]

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2. Knudsen AB, Rutter CM, Meester RGS, et al. Colorectal cancer screening in young adults. Ann Intern Med 2021;174:1039–1040.

Correction

Banerjee A, Herring CA, Chen B, et al. Succinate Produced by Intestinal Microbes Promotes Specification of Tuft Cells to Suppress Ileal Inflammation. Gastroenterology 2020;159:2101–2115.

In the above article, in the Methods section, there was an error in the dosage of anti-mouse CD3E. The correct dosage is 20 μg and the statement should read as follows: "Anti–CD3E-driven inflammation was induced in 2- or 3-month-old C57BL/6 males via retro-orbital administration of 20 μg/mouse of anti-mouse CD3E (145-2C11; BD Biosciences, San Jose, CA), with tissues collected at 0, 48, and 96 hours, with 48 hours being the key time point of heightened inflammation. Succinate supplementation was initiated 3 days prior to anti-CD3E treatment."