# Viral screening before initiation of biologics in patients with inflammatory bowel disease during the COVID-19 outbreak

We read with interest the Comment by Ren Mao and colleagues on the implications of coronavirus disease 2019 (COVID-19) in patients with pre-existing digestive diseases, and the strategies implemented in China to restrict the risk of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in patients with inflammatory bowel disease.[1]

We agree with the current evidence that does not support drug suspension and also with the European Crohn´s and Colitis Organisation COVID-19 Task Force's suggestion that, whenever possible during the COVID-19 pandemic, initiation of treatment with immunosuppressive drugs and biologics should be postponed based on an individual risk assessment.[2] However, for patients with substantial clinical activity, delaying the initiation of treatment might not always be possible.

A meta-analysis[3] of clinical trial data including 4135 patients given anti-tumor necrosis factor (TNF) therapy found that the relative risk of developing an opportunistic infection was 2·05 (95% CI 1·10–3·85) with anti-TNF therapy compared with placebo; opportunistic infections included tuberculosis, herpes simplex infection, oral or oesophageal candidiasis, herpes zoster virus, cytomegalovirus, and Epstein-Barr virus. A pooled analysis of 2266 patients given adalimumab found that higher disease activity was associated with significantly increased risks of both serious and opportunistic infections at 1 year.[4] Furthermore, vedolizumab, a humanised monoclonal antibody with gut selectivity, has been associated with airway and bowel infections, although to a lesser extent than with anti-TNF drugs.[5] The risk of opportunistic infection seems to be increased in patients with inflammatory bowel disease who are older than 50 years and receiving immunosuppression.[6,7]

As a result of this increased risk of opportunistic infections, inflammatory bowel disease guidelines suggest giving patients a viral screening before starting biologics.[8] In particular, the screening should include serology for hepatitis B virus, hepatitis C virus, HIV, and varicella zoster virus (in patients without a clear history of previous infection or vaccination), and tuberculosis screening through a combination of clinical risk stratification, chest x-ray, and IFN-γ release assays. Additionally, an assessment of history of specific infections is suggested, including herpes simplex virus, varicella zoster virus, and tuberculosis, and of immunisation status.[3]

Patients with inflammatory bowel disease might be at an increased risk of SARS-CoV-2 infection, and the risk of a severe clinical course of COVID-19 might be increased in individuals with chronic disease on immunomodulatory treatment. Furthermore, the risk of inducing clinical activation in individuals with asymptomatic SARS-CoV-2 infection cannot be excluded. As such, we believe that current recommendations for screening before initiation of biologics should be updated (at least temporarily) to include testing for SARS-CoV-2. In view of the rapid spread of the COVID-19 pandemic, we believe physicians should screen for COVID-19 even if patients are asymptomatic or do not have a history of high-risk travel or contact. However, importantly, the exact method of such screening should be decided on the basis of local policy and available health-care resources.

We declare no competing interests.

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