The National Clinical Programme in Gastroenterology and Hepatology
Guidance for Inflammatory Bowel Disease (IBD) services relating to COVID-19
Version 3 27th July 2020

1. Background

To help guide IBD services across the country during the COVID-19 outbreak the National Clinical Programme in Gastroenterology and Hepatology has outlined information and advice below. In as much as is possible we have linked to the most recent national guidance documents. Please check the HSE Repository for Interim Clinical Guidance intended for the Clinical Community for the latest version of all clinical guidance https://hse.drsteevenslibrary.ie/Covid19V2. This guidance document has been endorsed by the Irish Society of Gastroentrology. For further information please contact Prof Laurence Egan laurence.egan@nuigalway.ie

2. Risk factors and prevention of SARS-CoV-2 infection

Prevention of SARS-CoV-2 infection in IBD patients

All IBD patients should observe the standard HSE and government advice to minimize the risk of infection. This advice is available online at www2.hse.ie/coronavirus/

IBD as a risk factor for acquiring SARS-CoV-2

As of 2 June, 1379 IBD patients (worldwide) who acquired SARS-CoV-2 infection have been reported to the Secure-IBD registry (https://covidibd.org/). This includes 15 patients from Ireland. Even allowing for under-reporting, these data suggest that IBD is not a risk factor for SARS-CoV-2 infection. We encourage any IBD patient who tests positive for COVID-19 be registered in Secure-IBD. Of the patients in the Secure-IBD registry, 30% have been hospitalised, 6% required ICU admission and 3% have died. These numbers are too small to draw any conclusions.

3. Hospital preparedness

Standard operating procedure

Teams should also develop a standard operating procedure (SOP) for COVID-19 which contains local protocols. This should be shared with the hospital Multidisciplinary COVID-19 Preparedness Committee. The National Clinical Programme in Gastroenterology and Hepatology recognises that staff from endoscopy units may need to be redeployed to other duties as part of emergency response planning. We advise including contingency plans to facilitate continued delivery of services in the SOP.

4. Scheduling, risk assessment and vulnerable groups

Infusion units should continue to treat all patients.

For patients attending for IV treatment, there should be telephone pre-assessment 24 to 48 hours in advance of attendance to identify patients with risk factors and avoid attendance. Any patient who reports possible COVID-19 symptoms should be referred for testing and IV treatment should be delayed until negative swab results are available. If the virus is 'not detected' proceed with the treatment. If 'detected' defer until clinically well and 5 days afebrile with a minimum of 14 days from first symptom onset or test date (if onset unclear)

The Medication Safety Programme of the HSE has produced and updated guidance on immunosuppressant therapy and COVID-19. That guidance considers patients at normal risk of COVID-19, high risk, or very high risk. Age over 70, significant co-morbidities and the use of any or combinations of immunosuppressive drugs are the major factors to consider when stratifying patients risk of COVID-19.

However, international evidence in IBD patients has found that among immunosuppressant medications, only chronic corticosteroid use was associated with adverse outcomes of COVID-19. We therefore now propose the following third version of IBD-specific guidance in relation to cocooning and the risk of COVID-19:

At high risk: Patients aged over 70, with significant co-morbidity, or the use of corticosteroids greater than prednisolone 5mg/day. Cocooning at home is needed for this group, only when NPHET guidance indicates there is community transmission of SARS-CoV-2.

Social distancing and PPE during IV treatment

Patients must be scheduled in such a way that a minimum of two meters social distancing can be maintained in the unit. If the capacity of the unit is insufficient, mitigating actions such as screens and the use of PPE should be used. Stable patients could have infusions deferred for up to two weeks. However, this is a temporary solution only while service is being redesigned. Demand needs to be matched by capacity.

Where patients are attending the unit for IV treatment staff should follow the guidance issued by the HPSC on the use of PPE while performing such procedures. The latest guidance about PPE is available online at www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/

Please note that for patients undergoing IBD treatment without suspected or confirmed COVID-19, standard infection prevention control measures should be applied. For emergency procedures where adequate risk assessment for COVID-19 in advance of the procedure cannot be performed, precautions should be used as for cases of suspected or confirmed infection.

Considerations for outpatient clinics

Routine IBD patient follow up should be by virtual clinics using telephone or videoconferencing. Only new patients and those in significant flares should be seen face to face.

1. **Symptoms and treatment of COVID-19 in IBD patients**

Symptoms caused by COVID-19 in IBD patients

According to limited data, IBD patients present similarly to non-IBD patients with fever, dry cough, myalgia and the other usual clinical features of the disease. According to a study including 1,099 patients with laboratory-confirmed COVID-19 from 552 hospitals in China as of Jan 29, 2020, nausea or vomiting, or both, and diarrhoea were reported in 55 (5.6%) and 42 (3.8%) of patients. SARS-CoV-2 particles have been isolated from stool. Therefore, one should keep an open mind about

symptoms that might mimic an IBD flare and arrange viral swab for any IBD patient with a fever and who meets the current criteria for testing. Consider holding immunosuppressant agents, biologics and corticosteroids while awaiting swab results.

For further information see **Implications of COVID-19 for patients with pre-existing digestive diseases** which is online at www.thelancet.com/journals/langas/article/PIIS2468-1253(20)30076-5/fulltext

Treatment of IBD patients with COVID-19

Current recommendations are to individualise all treatment decisions in such IBD patients with COVID-19 in conjunction with infectious disease specialists. This likely to include holding of immunosuppressant agents and biological IBD treatments, but there is very little evidence to guide any such clinical decisions.

For additional information and international expert option please refer to the Update on COVID19 for Patients with Crohn's Disease and Ulcerative Colitis published by the International Organization for the Study of Inflammatory Bowel Diseases (IOIBD) www.ioibd.org and that available on the European Crohn's and Colitis Organization website https://ecco-ibd.eu/publications/covid-19.html

1. Other clinical considerations

Medication management and clinical trials

There is no evidence that any IBD medication increases the risk of contracting SARS-CoV-2 infection. Conversely, an IBD flare that resulted in significant morbidity might lead to worse outcome of COVID-19. Therefore, it is recommended that IBD patients should continue treatments except corticosteroids. Most clinical trials in IBD have paused recruitment but patients already enrolled should continue.

Endoscopy and scans

The HSE Acute Operations Endoscopy Programme has prepared guidance for the resumption of elective procedures. This guidance is available from Grace O'Sullivan, Programme Manager, HSE Acute Operations Endoscopy Programme graceosullivan@rcpi.ie 086 1409177.

Subcutaneous biologic and intravenous considerations

Switching from IV to SC biologics is an option to minimise hospital visits for IBD patients but flares could occur. When starting a biologic, an SC option may be preferable to minimise hospital visits.

IBD patients who are healthcare workers

Healthcare workers who have IBD patients and who are on immunosuppressant agents, systemic corticosteroids or biological drugs should stay at home. Such healthcare workers should contact local occupational health for additional guidance and support. Further national guidance in relation to Occupational Health is online at
www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/

Flu vaccine is strongly recommended for all IBD patients this and every year.

Appendix 1: Plain English advice for IBD patients during COVID-19 outbreak

You are not at increased risk of developing COVID-19 because you have IBD (Crohn's disease or ulcerative colitis).

You should follow all the HSE advice on cough etiquette, social distancing, and hand hygiene.

You should continue to take all your regular medicines for IBD unless your doctor advises otherwise.

If you are over 70 years, and have any serious illnesses other than IBD or are taking prednisolone at >5mg per day you should stay at home and cocoon, if NPHET says there is community transmission of coronavirus.

Latest guidance on at-risk groups can be found at:

https://www2.hse.ie/conditions/coronavirus/people-at-higher-risk.html

If you are an essential worker and are taking one of these medicines, you should discuss with your occupational health department before working.

For the most up to date national advice about cocooning please go to the HSE's dedicated COVID-19 advice page which is online at www2.hse.ie/conditions/coronavirus/at-risk-groups.html

If you develop symptoms of COVID-19 such as fever, cough or shortness of breath you should immediately contact your GP or consultant.

If you notice your IBD symptoms are getting worse (flaring), contact your GP or consultant.

There will be some changes in your follow-up at your hospital during the COVID-19 outbreak

- Clinic appointments will be mostly by telephone
- Routine scopes and scans will be deferred
- IV infusions may be delayed