Dear Colleague:

The COVID-19 pandemic is an unprecedented challenge for all healthcare systems worldwide. Gastroenterologists and clinicians who actively manage patients with inflammatory bowel disease (IBD), including ulcerative colitis (UC), need to ensure they are taking steps to minimize the risk of infection for their patients. Recently published (April 2020) *AGA Clinical Practice Update on Management of Inflammatory Bowel Disease During the COVID-19 Pandemic*, led by David T. Rubin, MD, and Russell D. Cohen, MD, from the Inflammatory Bowel Disease Center at the University of Chicago Medicine, highlights emerging evidence and the potential risk for COVID-19 in IBD patients, as well as recommendations for the treatment and management of patients with IBD during the coronavirus pandemic.

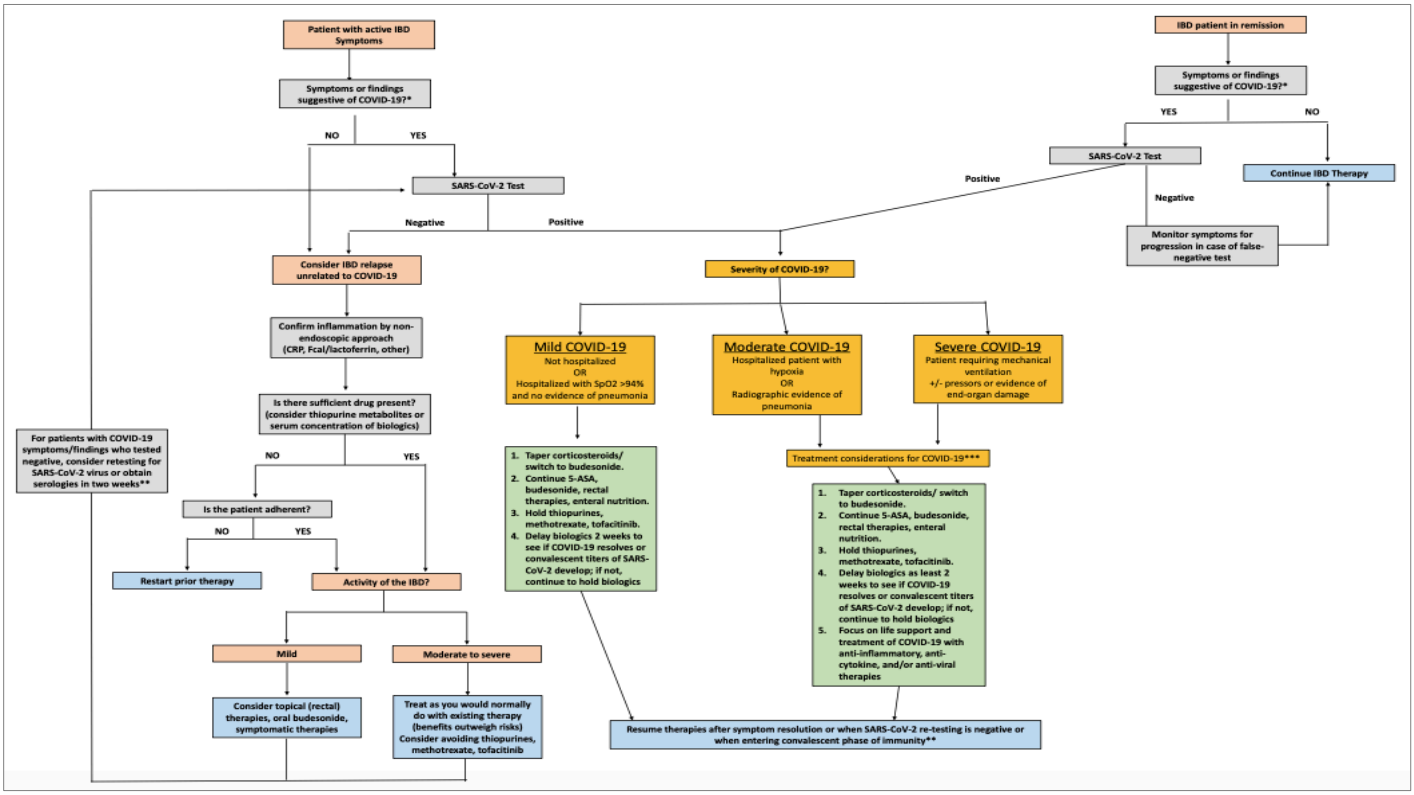
Please consider some key points from our certified activity, ***Meeting the Medical Needs of Patients with Ulcerative Colitis During the COVID-19 Pandemic*** in which we discuss how to identify, appropriately manage, and monitor patients with UC who test positive for COVID-19 through the use of an algorithm to guide complex clinical decisions for those who are symptomatic with or without suspicion of active UC inflammation.

1. **IBD medication adherence** is important. It is important to assess your patient's adherence and reinforce how critical it is to stay on their medication during this time to prevent disease flare. Physicians need to encourage their patients who require infusions to continue scheduled visits at their infusion center, which follow strict safety guidelines. AGA recommendations reiterate the importance of patients staying on therapies. Encourage any patient who has stopped taking their medication to get back on their appropriate therapy, even if they are feeling well, in order to prevent relapses. Emphasize that the IBD medicines are good and stopping prescribed therapy can be detrimental. Also, encourage your patients to contact you if they have concerns with any signs of potential COVID symptoms. You can review with your patients what those symptoms are, as well as specific resources available for IBD patients.

2. **Reduce or stop steroids.** The AGA and IOIBD (International Organization for the Study of Inflammatory Bowel Diseases) indicate high doses of systemic corticosteroids should be avoided. Patients at greater risk are those ≥60 years old, those with comorbidities, and those who continue use of systemic steroids. Data show patients on steroids had a 6-fold increase of acquiring severe COVID.

3. During this time of COVID it is necessary to **get your patients off systemic corticosteroids** and, if possible, onto non-steroid therapies, such as budesonide or onto a biologic. If your IBD patient has symptoms or is diagnosed with COVID, and is on azathioprine, 6-MP, methotrexate, or tofacitinib, it is suggested to hold the therapy at this point. You should restart their therapy after they are symptom-free or if they had follow-up serologic testing that was negative. If your patient is on prednisone, it is recommended to reduce the dose to below 20 mg. It is also recommended to switch therapy to mesalamine enemas, budesonide foam, or even hydrocortisone, if needed; although, some of the hydrocortisone is systemically absorbed. Switch to either oral or rectal budesonide, when feasible.

4. An **Algorithm Guide** (see image) developed by Dr. Rubin and Dr. Cohen and included in the *AGA Clinical Practice Update,* assists with complex clinical decisions to provide a guide if your patient is symptomatic or with active UC inflammation. The algorithm is carefully designed to provide management of patients with IBD during the COVD-19 pandemic, providing scenarios of what to do with active IBD symptoms vs if the patient is in remission.



5. Management of UC patients testing **positive for SARS-CoV-2 but who are asymptomatic.** Per AGA recommendations, patients with IBD who have known COVID-19, but have not developed COVID-19 symptoms, should taper use of corticosteroids, suggesting lower doses of prednisone (<20 mg/d), switching to budesonide when feasible, and holding thiopurines, methotrexate, and tofacitinib temporarily. Therapies may restart after complete symptom resolution, usually after 2 weeks, *or w*hen follow-up viral testing is negative or serologic tests demonstrate the convalescent stage of illness. Delay dosing of biologic monoclonal antibodies by 2 weeks while monitoring symptoms of COVID-19.

6. Treatment for patients who test **positive for SARS CoV-2 and who are symptomatic but without suspicion of active UC inflammation**: Determine first if the patient is in remission. Refer to the AGA and IOBD guidelines when deciding whether to hold or continue specific IBD therapies. Base treatment adjustment on the immune activity of the therapy and whether therapy may worsen outcomes with COVID-19. Many IBD therapies, such as aminosalicylates, sulfasalazine, budesonide, and topical rectal therapies are considered safe for continued use for COVID patients without active UC. Choose therapies that may have secondary benefit in IBD or that do not induce bowel inflammation. Discontinue thiopurines, methotrexate, tofacitinib. It is also recommended to discontinue anti-TNF therapy, specifically, ustekinumab and vedolizumab. Restart therapies after complete symptom resolution, plus follow-up viral or serologic tests to confirm recovery. Dosing of biological therapies should be delayed for 2 weeks, while monitoring for symptoms of COVID-19. Once patients have recovered, they may restart biologics.

7. Treatment for **symptomatic patients with active inflammation of UC**: Confirm active inflammation with nonendoscopic tests. Limit endoscopy, but clinical scenarios that may prompt endoscopy include the need to obtain biopsies to diagnose new, severe IBD. Exclude cytomegalovirus (CMV) if noninvasive tests are equivocal.

Note that CMV testing may be done as a serum polymerase chain reaction to avoid need for colonoscopic procedures or in patients with severe disease or suspected cancer where mucosal inspection might direct surgical intervention. In mildly active UC, safer therapies include 5-ASA (for UC), budesonide (for Chron's disease and UC), and partial or full enteral nutrition (CD, mostly pediatric). For moderate-to-severely active UC, maintain usual treatments, reiterating the need to avoid steroids, if possible (even for induction), and treat with the same therapies you would choose in the pre-COVID-19 era.

8. **Managing patients hospitalized for UC.** For patient with mild COVID symptoms, standard treatment for UC is recommended, but limit IV steroids to 3 days. With severe COVID symptoms, UC therapy is not recommended. Exceptions include some treatments that may enhance COVID therapy. Avoid surgery with stopgap measures. And surgery should only be performed in emergent situations. Decided on a case-by-case basis in discussions with surgery colleagues, keeping in mind limited operating room and resources, as well as the lack of on-site availability of family members for patient support.

9. The Surveillance Epidemiology of Coronavirus Under Research Exclusion **(SECURE)-IBD database** is an international collaboration between experts in epidemiology and IBD to create a voluntary registry for professionals to report patients who test positive for SARS-COV-2. SECURE-IBD is publicly accessible and tracks the impact and clinical outcomes, as well as the epidemiology of COVID-19 among individuals with IBD. Gastroenterologists and clinicians treating patients with IBD are encouraged to report all cases of confirmed COVID-19 in individuals with IBD after 7 or more days, with sufficient time to observe the disease course through resolution of acute illness and/or death. **Please visit** https://covidibd.org. Your contributions will continue to help build a robust registry.

10. **Post-pandemic consideration**: Pertinent questions for gastroenterologists and those treating patients with UC, include addressing lapses in monitoring and follow-up, as well as assessing patient adherence to their prescribed therapy. Consider reintroduction to therapy and uncover symptom exacerbation. As ever, good patient communication is essential.

During this urgent time, it is essential to personalize your therapeutic approach to you patient's needs based on the balance between risk of viral infection and the risk of disease recurrence. When possible, avoid high doses of systemic corticosteroids. Don't stop anti-TNF therapy or other biologics unless the patient is diagnosed with active SARS COV-2, and then hold off for 2 weeks, unless the infection worsens. With the continued evolution in our care of patients with IBD, we can ensure clinicians are taking steps to minimize the risk of infection for their patients. And please remember to report your cases to the database: **covidibd.org.** Become one of the valiant caregivers to help provide more information about what happens to IBD patients who test positive with COVID.

Yours sincerely,

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