

Care of the IBD Patient Requiring Hospitalization or Surgery During the COVID-19 Pandemic

IOIBD Hospitalization Task Force:

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Setting

Interpretation of these recommendations should be in the context of the prevalence of COVID-19 in your community, availability of healthcare resources including personal protection equipment, available personnel and local regulations or policies related to the pandemic.

Criteria for admission

- Patients with severe, complicated or progressive disease should be evaluated and admitted as prior to the pandemic. **Patients who are less active but who would under usual circumstances be admitted for medically resistant disease should not be electively admitted at this time.**
- If available, **rapid access outpatient evaluation and outpatient treatment escalation is preferable.** When appropriate and available, telemedicine options should be utilized <https://www.ioibd.org/wp-content/uploads/2020/05/IOIBD-Taskforce-Telemedicine-COVID-19-and-IBD-guidelines.pdf>
- Patients with IBD and COVID-19 should be admitted based on considerations of the severity of the COVID-19 and the severity of the IBD.
- **Bypassing the emergency room with direct admission to the hospital ward is preferable.** However, this will depend on admission protocols in place at individual hospitals.
- When possible, and after appropriate testing, admission to a COVID-free unit should occur.

Evaluation for COVID-19

- It is unknown if SARS-CoV-2 can cause relapse or *de novo* IBD¹.
- Patients suspected of having COVID-19 should be tested for SARS-CoV-19 in the oropharynx or when available with serologic antibody testing.
- **Universal stool testing for SARS-CoV-2 is not recommended at this time.**
- Patients positive for SARS-CoV-19 or suspected to have COVID-19 should be isolated in a negative pressure room. Healthcare workers should utilize appropriate personal protective equipment.
- Depending on institutional policy and availability, testing for COVID-19 may be required prior to needed inpatient endoscopic, radiologic or surgical procedures, as even asymptomatic COVID-19 patients may be at risk for postoperative ICU care and mortality^{2,3}.

Diagnostic considerations

- Laboratory investigations should be chosen and utilized to minimize need for interventions and to those that will directly influence medical or surgical management, with mindfulness on laboratory resource utilization. The usual approach to active IBD should be performed, including evaluation for enteric infections other than SARS-CoV-2.
- Radiologic procedures should be limited to those that are urgently needed or will directly influence management. For example, AXR, CT or MR to evaluate for abscess or obstruction. **In the current environment, CT may be preferred over MR due to faster acquisition time and easier deep cleaning of equipment.**
- Endoscopic procedures should be limited to those that are urgently needed or will directly influence management. **Serum and stool biomarkers may have a more prominent role to play in this setting.**

<https://www.ioibd.org/wp-content/uploads/2020/05/IOIBD-Taskforce-Endoscopy-COVID-19-and-IBD-guidelines.pdf>

Considerations for treatment of IBD in a patient with SARS-CoV-2

- **Table 1** is a summary of treatment considerations based on IBD and COVID severity. This table is mainly based on expert opinion and published recommendations from professional bodies⁴.
- **Choice of IBD therapies in this setting must be considered in the context of the severity of the COVID-19.**
- In cases of moderate-severe COVID-19, priority should be given to supportive care and management of the COVID-19. There is interest in ongoing clinical research and whether some therapies for COVID-19 would be safe and have secondary benefit in IBD patients.
- Given the standard of practice for all hospitalized IBD patients and the emerging understanding of hypercoagulability associated with severe COVID-19, **patients with COVID-19 and active IBD require a specific attention regarding heparin prophylaxis^{5,6,7,8}.**
 - Doses of heparin required should be in line with current recommendations, considering both IBD and COVID-19 risks.

Table 1

	No SARS-CoV-2	SARS-CoV-2 positive, but NO COVID-19	Mild COVID-19 Not hospitalized OR Hospitalized with SpO2 >94% and no evidence of pneumonia	Moderate COVID-19 (Hospitalized patient with hypoxia OR Radiographic evidence of pneumonia) OR Severe COVID-19 (Patient requiring mechanical ventilation +/- pressors or evidence of end organ damage)
IBD remission	<ul style="list-style-type: none"> Taper or discontinue prednisone Continue all other IBD meds 	<ul style="list-style-type: none"> If IBD stable, wait for 2 weeks for COVID-19 to present or until convalescent titers of SARS-CoV-2 develop. Taper or discontinue prednisone. Discontinue thiopurines, MTX, tofacitinib for 2 weeks. Delay dosing of biologics for 2 weeks. 	<ul style="list-style-type: none"> Taper or discontinue prednisone. Discontinue thiopurines, MTX, tofacitinib. Discontinue biological therapies. Restart IBD therapy when COVID-19 resolved (symptoms and when validated, serological testing of convalescent titers of SARS-CoV-2 immunity). 	<ul style="list-style-type: none"> Taper or discontinue prednisone. Discontinue immune based IBD therapies. Focus on life support and if available, treatment of COVID-19 with anti-viral or other anti-inflammatory/anti-cytokine therapies. Prophylaxis against VTE for COVID-19
IBD mildly active	<ul style="list-style-type: none"> Treat with any IBD therapies necessary. Limit use of oral or IV steroids to shortest time possible, choose alternatives when possible. 	<ul style="list-style-type: none"> If IBD stable, wait for 2 weeks for COVID-19 to present or until convalescent titers of SARS-CoV-2 develop. If treatment needed, budesonide, 5-ASA, rectal therapies ok. Consider holding immune therapies and biologics for 2 weeks. 	<ul style="list-style-type: none"> If IBD stable, wait for 2 weeks for COVID-19 symptoms to resolve or until convalescent titers of SARS-CoV-2 develop. If treatment needed, budesonide, 5-ASA, rectal therapies ok. Taper or discontinue prednisone. Discontinue thiopurines, MTX, tofacitinib for 2 weeks. Delay dosing of biologics for 2 weeks. 	<ul style="list-style-type: none"> Taper or discontinue prednisone. Discontinue immune based IBD therapies. Focus on life support and if available, treatment of COVID-19 with anti-viral or other anti-inflammatory/anti-cytokine therapies. Prophylaxis against VTE for IBD and for COVID-19
IBD moderately - severely active	<ul style="list-style-type: none"> Treat with any IBD therapies necessary. Limit use of oral or IV steroids to shortest time possible, choose alternatives when possible. Prophylaxis against VTE (if hospitalized) 	<ul style="list-style-type: none"> Limited use of corticosteroids ≤40 mg/d if necessary. Avoid thiopurines, MTX, tofacitinib. Escalate to biological therapies as needed. If hospitalized, consider IV cyclosporine for UC given limited evidence of benefit against coronavirus. Prophylaxis against VTE For IBD. 	<ul style="list-style-type: none"> Limited use of steroids ≤40 mg/d if necessary. Avoid thiopurines, MTX, tofacitinib. Escalate to biological therapies as needed. Prophylaxis against VTE for IBD 	<ul style="list-style-type: none"> Limited use of IV steroids for IBD only if necessary. Topical (rectal) therapy if needed. Discontinue immune therapies or biologics that are not working for the IBD. Prophylaxis against VTE for IBD and for COVID-19 Careful consideration of other therapies for IBD only as absolutely needed. Consider cyclosporine for UC given limited evidence of benefit against coronavirus. Focus on life support and if available, treatment of COVID-19 with anti-viral or other anti-inflammatory/anti-cytokine therapies.

Treatment of the IBD patient hospitalized for medically resistant disease (and without COVID-19)

- Given the risk of COVID-19 in the community or even in the hospital, choices of therapy should be based on combination of efficacy, safety, speed of onset, and limitation of need for outpatient monitoring.
- Length of stay should be minimized but should not compromise successful disease control.
- Consider supportive care with exclusive enteral nutrition in Crohn's disease patients.

- Although surgical societies have recommended that elective surgical cases be postponed, surgery for imminently life-threatening conditions such as medically refractory severe UC (or cancer development) should continue as clinically indicated^{2,9}. This minimizes the risk to both patient and health care team, as well as minimizes utilization of necessary resources, such as beds, ventilators, and personal protective equipment (PPE).
- Colectomy for severe/fulminant UC. This is time sensitive and may be urgent and should be performed depending on available resources and engagement of medical and surgical teams.
- Surgery for IBD patients with dysplasia or cancer should be delayed at the current time and rescheduled when resources are available. Delays should be minimized as much as possible within the limits of available resources. Clinicians should maintain accurate records of deferred procedures and should prioritize these patients once surgical slots become available.
- Treatment of perianal disease and/or perineal sepsis in CD
 - Surgery for asymptomatic perianal fistulas should be postponed. Setons can remain in place. Seton removal alone in patients on biologic therapy should be reconsidered in order to minimize recurrent abscess formation and need for further hospitalization.
 - Smaller perianal abscesses. The role of oral antibiotic therapy alone versus surgical drainage for small abscesses in these patients is unknown. It is reasonable to try a short course of antibiotic therapy before surgery.
 - Larger perineal abscess. The presence of a large or complex perianal abscess in the CD patient requires surgery and should not be delayed.
- Surgery for CD
 - Bowel obstruction.
 - Modification of nasogastric (NG) suctioning handling. As the virus has been isolated from multiple cells and body fluids including enteric contents¹⁰, placement and handling of NG tubes should be performed by care members donning appropriate PPE, including gowns and face shields.
 - CD patients with intestinal obstruction not improving with medical therapy require surgery including strictureplasty and/or resection with primary anastomosis.
 - The value of performing a stoma routinely in these cases, although advised by some societies to reduce need for unplanned post-operative critical care for complications¹¹, is of uncertain benefit.
 - Intra-abdominal abscess
 - Treat with standard approach to drainage of the abscess, bowel rest and antibiotic therapy.
 - When needed, surgery in this situation should not be delayed

Communication with patients and family

- Exclusion of visitors in the hospital during hospitalization or recovery. Most hospitals are not allowing visitors in any patient care areas, exceptions being one caregiver for patients under the age of 18, in-person discharge instructions, labor and delivery patients, and before and during surgery. The social and emotional impact of these policies on the IBD patient requiring hospitalization or facing surgery are formidable.
- **Efforts should be made to communicate with family and to encourage video conferencing with family and patients when possible.**