Transcript Details
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IBD & COVID-19: How to Manage Patients Amid the Pandemic

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch, and here to help us better understand the management of inflammatory bowel disease during the COVID-19 pandemic is Dr. Asher Kornbluth. Dr. Kornbluth is a Clinical Professor of Medicine and Gastroenterology at Mount Sinai School of Medicine in New York. Dr. Kornbluth is also the lead author of the article titled, "Management of Inflammatory Bowel Disease and COVID-19 in New York City, 2020: The Epicenter of IBD in the First Epicenter of the Global Pandemic," which was published in *Inflammatory Bowel Disease Journal* in 2020. Welcome to the program, Dr. Kornbluth.

Dr. Kornbluth:
Thanks, Peter, for having me.

Dr. Buch:
It's a true pleasure. To start us off, Dr. Kornbluth, can you tell us if patients with inflammatory bowel disease are at increased risk of COVID-19?

Dr. Kornbluth:
So that's a really important question because we have patients who are on a lot of immunosuppressant meds, and they know that Crohn's disease and ulcerative colitis – the inflammatory bowel diseases – are immune-mediated diseases. So they're frightful from day one, back in March of 2020, that they're more likely to get COVID. So I explain to them that Crohn's disease and ulcerative colitis are diseases whereby our immune systems are really overactive. They're jazzed up, they attack our own colon and small intestine. It's not a disease of an underactive immune system, so in that sense, they're not at increased risk of getting COVID-19. There are some big national databases. Some of them based of par and pharmaceutical claims databases, some of them based out of the national GA database. There is no increased risk of getting COVID-19 if you have IBD. Except if you're on steroids.

Dr. Buch:
Great. And what's the concern regarding the use of steroids?

Dr. Kornbluth:
So we have found through a registry started by Ryan Garrow and some folks at University of North Carolina – Ryan's here at Mount Sinai – that there's this database, a secure IBD registry, which is in fact, I believe, of all the autoimmune diseases that have founded registries and posted them on the internet. I think this is the largest, and as of last Tuesday, because it gets updated weekly, there are over 6,000 patients from 64 countries and counting, that reported cases in the world.

Now from the beginning, from the very first patients, the signal was clear that steroids, number one, from other databases, increases the risk of getting COVID to start with, and very importantly, number two, if you are on steroids, greatly increases the relative risk of bad outcomes. In terms of this registry, a bad outcome was very simply defined as hospitalization, ICU and ventilator, and death. Very simple. Wasn't going through lots of patient charts. These were self-reports from doctors and this registry was actually designed that anyone could enter a patient in five minutes or less. So this was not poring through charts and scores of pages and pages and computer screens of outcomes. Very simple. Bad outcome equals hospitalization, ICU ventilator, and death. The relative risk in a multi-varied analysis when you account for all the other important variables, which in short are age over 65 and having multiple comorbidities, the relative risk of one of those bad outcomes on steroids was eightfold. Eightfold is likely in patients on prednisone, 20 milligrams or more, in having a bad outcome. So steroids, among all of our medicines, increased the risk of getting COVID, and number two, increases the risk very significantly of bad outcomes.

Dr. Buch:
So with that being said, how would you treat a patient with inflammatory bowel disease who has active COVID-19?

Dr. Kornbluth:
That's a great question, because I just mentioned that other than steroids, our other meds like immunosuppressants don't increase the risk of getting COVID, number one, and number two, none of these meds appear to increase the risk of bad outcomes, and what we've learned from Secure is that patients on the anti-TNF's – Remicade, Humira, Cimzia, Simponi – actually have a significantly reduced risk of bad outcomes. Similarly, with Stelara, or Entyvio, or even tofacitinib, decreased risks of bad outcomes. Six MPNAs of Thioprin, what we call the thiopurines – that, like steroids, do increase risk of bad outcomes. But all our other medications do not. Having said that, the standard guidelines first published by the International Organization for IBD, known as the IOIBD, way back last April, and the AGA, and the ACG basically said, "Well, if you're in the midst of an infection, we should probably hold those medications." It probably isn't the case, and we have to weigh the risks and benefit, and there's sort of a calculus here, weighing the severity of the COVID versus the severity of the IBD. Now let's say you have someone with very mild COVID, maybe a little loss of scent/smell, maybe low-grade fever, a little achy, for a couple days, and they really were much better on their anti-TNF or Stelara or Entyvio and really had a lot to lose if they were to flare again. That's a patient we probably wouldn't hold the medication at all these days. On the other hand, they're very severe COVID, they're looking at the ICU, they've just come off a bad, bad bout, we'd probably hold the medications, even though, again, it doesn't increase the risk of a bad outcome in the global sense. But again, we weigh the risks and the benefits.

Having said that, the one medication we work really hard to get our patients off is prednisone and the other steroids. Now there's one point I wanna make here so people don't get confused. There's a very important study, and probably the first medication that was proven in large, randomized control trials that have an impact on mortality in COVID in general – this is outside of IBD – are steroids: dexamethasone. And that is really a fundamental basis of the hospitalized, sick patients now with dexamethasone steroid. So you say, well how do you reconcile this finding that steroids make you more likely to get COVID, make COVID worse, versus the sickest patients get better with dexamethasone? And the answer is the following: Steroids get you sick in the first place because it's an immunosuppressant, makes it more likely you'll get the virus, and the virus continues unchecked. The patients are getting really sick with COVID. It's not so much from widespread penetration at that point of the virus. What's happened in those patients is that the virus has triggered what's well known now as the cytokine storm. And among those cytokines are cytokines that are suppressed by dexamethasone, and in fact by Remicade and some of our other immunosuppressant meds. So early on, steroids is the curse in the patient who is highly dependent on oxygen is looking at an ICU admission. Those patients, in fact, do get better with dexamethasone. So it all is about where in the course you're looking at giving them steroids.

Dr. Buch:
Thank you. For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch, and today I'm discussing inflammatory bowel disease and COVID-19 with Dr. Asher Kornbluth. So are there any concerns about IBD patients receiving COVID-19 vaccinations?

Dr. Kornbluth:
This is maybe the most important question we're gonna talk about today, Peter, and the answer is 100%, unequivocally, no contraindications about getting the vaccine if you have IBD. No concerns. The most important message is if you have IBD, and no matter what medicine you're on, get the vaccine. There are not live components to the vaccines we have available to us, and there is sometimes confusion because people, especially with the J&J vaccine, hear that it's an adenovirus that's involved with this. So let me just clarify what these vaccines are and our general principles about vaccinating and IBD. Our IBD patients on our immunosuppressive drugs, yes they are at increased risk of infections in general, and in general, one of the mainstays of our preventive medicine is to make sure they're getting their vaccines on a regular basis, namely annual influenza injections above a certain age, Shingrix vaccinations for zoster, and Prevnar followed by pneumococcal vaccine. If their kid's going off to college or to the military, they should get meningococcal vaccine as well. These are all non-live vaccine. We're very cautious about telling patients you can get live vaccines, such as MMR – measles, mumps, rubella – those kids who let's say in their junior year of college want to go off to underdeveloped nations where they have to worry about yellow fever, they can get yellow fever vaccine – that's a live vaccine. So those are some of the tenets of our vaccinations. We want our IBD patients to get vaccinated. The question, "When should they get vaccinated? Where, perhaps in their cycle of infusions or injections?" We don't know the answer to it, but our answer is the best time to get vaccinated is when you can get the vaccine. Don't put it off. What's the best vaccine for our patients to get? The one they can get. So we want our patients to get vaccinated as soon as possible. And where we stand now in the country, fortunately there's widespread access. As you know, there's at this point more of a supply problem than a demand problem. But we really work very hard to encourage our patients to get vaccinated.

Dr. Buch:
Thank you for that. Can COVID-19 cause any long-term harm in our IBD patients?

Dr. Kornbluth:
Yeah, so now we have, let's say 15 months plus, of this horrible, horrible nightmare of a disease for our patients, and by now we would have seen in our hundreds of thousands of patients signals of toxicity from COVID per se, and we're not finding that COVID has been triggering flare-ups. We're not finding that the medications, as I said, is triggering COVID outbreaks or worse outcomes, and we're also not finding that COVID exacerbates the disease or that the vaccines might trigger disease.

So although COVID might cause nonspecific symptoms in say, ten or fifteen percent of patients, that's not the same as saying it's triggering IBD. It's causing GI symptoms in our IBD patients, chiefly some queasiness, some nausea, some diarrhea – much in the same way that it'll affect the GI system in patients without IBD. So it is not likely to trigger IBD attacks.

Dr. Buch:
Great. And lastly, Dr. Kornbluth, what have you learned about COVID-19 and IBD since you published your article?

Dr. Kornbluth:
Well, first of all, let me plug that article. It's basically almost a narrative diary of what it was like taking care of patients with IBD in New York City, March, April, May of 2020. It was a very specific time in a very specific place of the universe. What we've learned in terms of IBD is probably, if anything, our medications don't need to be held outside of steroids. So we're less likely to rush to stop our biologics in our patients with IBD. So that's probably the biggest lesson. We've also, even early on, learned how to distinguish the non-specific GI symptoms from IBD and not get fooled about drumming up the dial on our IBD meds. Other than that, within the GI universe, we haven't had much evolution. Early on, the predictions we made about the effect of medications, the harm of steroids, have pretty much held up over this last year and a few months.

Dr. Buch:
So we've come a long way since the onset of COVID-19, and I want to thank Dr. Asher Kornbluth for sharing his insights on how we can manage our IBD patients amidst this global pandemic. Dr. Kornbluth, thanks so much for your insights.

Dr. Kornbluth:
Thanks so much for having me, Peter. It's been a real honor. Thank you.

Dr. Buch:
For ReachMD, GI Insights, this is Dr. Peter Buch. To access this episode, as well as others from the series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for joining us, and see you next time.