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who do not have symptoms suggestive of COVID-19, immunosuppressive and biological drugs should not be discontinued as a preventive strategy, since there is no evidence to date to suggest that there is an increased risk of SARS-CoV-2 infection with these therapies.⁴⁻⁶ In addition, patients are recommended to stay at home, avoid travel, respect the rules of social distancing (at least 1 m between one person and another), pay close attention to hand hygiene, and use protective masks outside the home.⁴⁻⁶ In this context, patient associations are a key link between doctors and patients and should be increasingly involved in patient management. Close cooperation could allow greater patient compliance with the recommendations of health-care providers and could also help to establish long-lasting, trusting relationships.

J-FR has received lecture fees from AbbVie, Merck Sharp and Dohme (MSD), Takeda, Pfizer, Ferring, and Falk; consulting fees from AbbVie, Takeda, Hospira, Mundipharma, MSD, Pfizer, GlaxoSmithKline, and Amgen; and research support from Takeda and AbbVie. LP-B has received personal fees from AbbVie, Janssen, Genentech, Ferring, Tillots, Pharmacosmos, Celltrion, Takeda, Boehringer Ingelheim, Pfizer, Index Pharmaceuticals, Sandoz, Celgene, Biogen, Samsung Bioepis, Alma, Sterna, Nestle, Enterome, Allergan, MSD, Roche, Arena, Gilead, Hikma, Amgen, Bristol-Myers Squibb, Vifor, Norgine, Mylan, Lilly, Fresenius Kabi, Opplian Pharma, Sublimity Therapeutics, Applied Molecular Transport, OSE Immunotherapeutics, Entera, and Theravance; grants from AbbVie, MSD, and Takeda; and stock options from Clinical Trials Mobile Application. SD has served as a speaker, consultant, and advisory board member for Schering-Plough, AbbVie, Actelion, Alphawasserman, AstraZeneca, Cellerix, Cosmo Pharmaceuticals, Ferring,

Genentech, Grunenthal, Johnson and Johnson, Millenium Takeda, MSD, Nikkiso Europe, Novo Nordisk, Nycomed, Pfizer, Pharmacosmos, UCB Pharma, and Vifor. FD'A and SL declare no competing interests.

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Patterns of care for inflammatory bowel disease in China during the COVID-19 pandemic

Published Online
May 13, 2020
[https://doi.org/10.1016/S2468-1253\(20\)30131-X](https://doi.org/10.1016/S2468-1253(20)30131-X)

More than 2.7 million individuals worldwide have been infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and 187 000 have died from the resulting coronavirus disease 2019 (COVID-19) as of April 25, 2020.¹ Despite the common use of immunosuppressive medications, it appears that patients with inflammatory bowel disease (IBD) have a similar risk for COVID-19 to the general population.² The management of IBD during and after the pandemic is challenging. The main concerns from a clinician's perspective are the risk for COVID-19 in patients with IBD (especially in those taking immunosuppressive medications or with malnutrition), timely follow-up and monitoring of disease, choice of and change in medical and surgical therapy, feasibility and availability of endoscopic

assessment, and protection of health-care providers against SARS-CoV-2 infection.³⁻⁷ Additional concerns have been raised from the patients' perspective, including medical, psychosocial, and financial factors. Therefore, we did a survey involving patients with IBD to analyse their feedback on their care during the early and late phases of the COVID-19 outbreak in China. The anonymous questionnaire was designed by clinicians, registered nurses, and patient representatives and was posted on the China Crohn's and Colitis Foundation's patient portal.

2277 participants completed the survey. 880 (39%) were women and 1397 (61%) men; 1639 (72%) had Crohn's disease and 555 (24%) had ulcerative colitis. 111 (5%) respondents were from Hubei province. Of the 2277 respondents, 1134 (50%) were employed full

or part time. Most (934 [82%] of 1134) had to work at home during the pandemic and 443 (39%) reported reduced income (appendix).

More than 50% of the respondents reported some degree of mood changes, with the peak of the frequency of moderate-to-severe psychological change in the middle of the outbreak in China—ie, mid-February, 2020. Many (1331 [58%] of 2277) respondents were worried about the risk for SARS-CoV-2 infection for themselves and their family and more than half (1184 [52%]) were concerned about the difficulty in seeing physicians (appendix).

Almost three-quarters of patients (1691 [74%]) reported that their disease state was stable during the initial outbreak (from January to March, 2020) and 1842 (81%) reported that their disease remained stable in the later phase (ie, mid-April, 2020). 137 (6%) patients were admitted for IBD flares and 23 (1%) had surgery. 639 (28%) patients used telemedicine—of whom 487 (76%) sought help from IBD health-care providers online—and 847 (37%) of 2277 patients had face-to-face visits. Most patients (1744 [77%]) did not change IBD medications during the outbreak. Of the 533 patients with a change in medications, the main reasons for the change were recommendations from treating physicians (157 [30%]), being unable to receive intravenous infusions (151 [28%]), and the availability of physicians or facilities (148 [28%]). Most respondents (1606 [71%] of 2277) were still able to obtain oral medications online (1125 [49%]) or from hospital pharmacies as before (481 [21%]). By mid-April, 2020, most (1628 [71%]) were able to obtain oral medicines from their hospital pharmacies as before (appendix).

The COVID-19 pandemic has posed challenges to every aspect of respondents' lives. Measures to curtail the virus, such as shelter-in-place, government mandates for postponing elective procedures, restriction of transportation, and the reassignment of gastroenterologists or IBD health-care providers, can interfere with routine or emergent care. Most patients with IBD experienced stable disease during the early and current phases of the outbreak and those individuals did not have to change their medications. Our survey data suggest that the impact of the COVID-19 outbreak on medical management of IBD was largely related to logistics. Restructuring IBD care, such as personnel reassignment, infusion service availability, drug delivery,

and telemedicine, have been proposed as being important for IBD management during such a pandemic.⁸ Our survey shows that a quarter of patients sought care via telemedicine with their IBD physicians. There was also increased use of online delivery of oral medications.

Mental health issues have been reported by both patients and health-care providers during the outbreak.^{9,10} Mental health issues are particularly important in patients with diseases of long duration, such as IBD. Our survey suggests that although patients' moods were affected by concerns about psychosocial and economic issues, their disease course was not affected. Respondents were concerned about the risk of infection and worried about access to health care. More than 50% of respondents had mood changes and their mood changes appeared to improve as the pandemic trend was flattening. More than 80% of employed respondents had to work from home and 40% of the respondents reported a reduced income. The financial impact can be long lasting, which could affect the affordability of and adherence to medical care. This could eventually alter disease outcomes.

The results from this large survey suggest that the COVID-19 pandemic affects patients with IBD medically, psychosocially, and financially. Most respondents' disease remained stable. Respondents using maintenance therapy and those requiring medication adjustments because of disease flares often met logistical challenges. The availability of telemedicine and online drug delivery services might have eased some of the burden. Psychosocial and economic effects of the pandemic on IBD care are common. The long-lasting effects will need to be studied over time.

FAF has served as a consultant for Bristol-Myers Squibb, Braintree Labs, Gilead, GlaxoSmithKline, Innovation Pharmaceuticals, Janssen, Pfizer, and Sebel, and sits on a data safety monitoring board for Lilly and Theravance. CNB has served on advisory boards for AbbVie Canada, Roche Canada, Janssen Canada, Takeda Canada, and Pfizer Canada; has been a consultant for Mylan Pharmaceuticals; and has received educational grants from AbbVie Canada, Pfizer Canada, Takeda Canada, and Janssen Canada; and acted as a speaker for Janssen Canada, AbbVie Canada, Medtronic Canada, and Takeda Canada. BS has served as a consultant and speaker for AbbVie, Janssen, and Takeda. YC, SH, HW, J-JZ, and RPK declare no competing interests. The authors are grateful to support from surveyed patients. The study was approved by the ethics committee of the Second Affiliated Hospital, School of Medicine, Zhejiang University (Hangzhou, China). YC, SH, and HW contributed equally to this Comment.

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See Online for appendix

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Converging pandemics: implications of COVID-19 for the viral hepatitis response in sub-Saharan Africa

Sub-Saharan Africa is currently bracing itself as the next front in the fight against the coronavirus disease 2019 (COVID-19) pandemic. Despite low testing capacity, 61991 cases and 1778 deaths had been reported in the WHO Africa Region as of May 18, 2020, with a recent increase in reported daily cases and deaths. Despite younger age demographics and less travel than in other regions, and strong efforts for early containment, the potential for widespread community-based transmission in sub-Saharan Africa is high, but current modelled estimates vary widely. Poor baseline health status, overcrowded urban housing conditions, and limited health-care infrastructure for testing, contact tracing, and treatment could exacerbate the expected morbidity and mortality. Certainly, there will be an accompanying loss of economic growth, and millions could be impoverished.¹

There has been speculation about the potential impact of COVID-19 on people living with well recognised, pre-existing conditions in sub-Saharan Africa (eg, HIV, tuberculosis, and malaria), as well as the potential implications for reproductive, maternal, child, and neonatal health and nutrition.² However, the implications for people living with viral hepatitis have not yet been well considered. Hepatitis B virus (HBV) and hepatitis C virus (HCV) infections are estimated to

affect 71 million people in sub-Saharan Africa, more than three times the number infected with HIV in the region, and comprising more than a fifth of the global burden of viral hepatitis.³ Only 1% of these individuals have been diagnosed. As clinicians, researchers, and programme implementers in sub-Saharan Africa, our concerns regarding the impact of the COVID-19 pandemic on people living with viral hepatitis in sub-Saharan Africa can be described in three major areas.

First, people with viral hepatitis-related liver disease in sub-Saharan Africa are likely to remain undiagnosed or to present at very late stages of disease. This is evidenced by sub-Saharan Africa having the highest death rate from liver cirrhosis in the world (32.2 deaths per 100 000 population).⁴ Guidelines from the US Centers for Disease Control and Prevention have included patients with chronic liver disease as a vulnerable population with increased risk for severe manifestations of COVID-19.⁵ Although the presence of viral hepatitis does not seem to increase susceptibility to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, there is increasing evidence that the innate immune response to SARS-CoV-2 infection results in liver damage.^{6,7} SARS-CoV-2 infection might therefore be an important risk factor for critical disease and

For the WHO Africa Dashboard see <https://www.afro.who.int/health-topics/coronavirus-covid-19>